Covid-19 Risk
Informed Consent Form

I ________________________ (patient name) understand that I am opting for an elective treatment/procedure that is not urgent and may not be medically necessary.

I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing.

I recognize that the physicians, physician assistants, and all the staff at The Enhancers are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19.

However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment/procedure

I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure and I give my permission for the physicians/physician assistants and all the staff at The Enhancers to proceed with the same.

I confirm neither I nor any individual living with me has any of the COVID-19 symptoms listed on the COVID-19 questionnaire provided to me and neither I nor any individual living with me during the past 14 days has experienced any such symptoms

I understand that, even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test.

I understand that possible exposure to COVID-19 before/during/after my treatment/procedure may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death.

I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment/procedure itself.

I also understand having my elective treatment/procedure performed at this time increases the risk of my transmission of COVID-19 to my provider. This virus has a long incubation period, there may be as yet unknown aspects of its transmission, and I realize that I may be contagious, whether or not I have been tested or have symptoms.

I understand to reduce the possibility of COVID-19 exposure or transmission at the office, I accept that my provider will implement infection-control procedures with which I must comply, before, during and after my procedure, for my own protection as well as that of my provider.

I understand my cooperation is mandatory, whether or not I personally feel such COVID-19 procedures and/or preventive measures are necessary

I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment/procedure.

_____ Patient Initials

I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE PROCEDURE.

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Patient or Person Authorized to Sign for Patient

Date/Time___________________________

I have been offered a copy of this consent form (patient's initials) ______