



### **COVID-19 Informed Consent to Treatment**

I understand that the World Health Organization (WHO) has declared the novel Corona virus (COVID-19) a global pandemic. I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

**To proceed with receiving care, I confirm and understand the following:**

- I understand my treatment may create circumstances such as the discharge of respiratory droplets or person -to-person contact, in which COVID-19 can be transmitted.
  
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care.
  
- I understand that I'm opting for an elective treatment that may not be urgent or medically necessary. I understand there are alternatives for receiving this care, which includes receiving care for another type of provider or postponing care at this time. However, while I understand the potential risks associated with receiving treatment during COVID-19 pandemic, I agree to proceed with treatment at this time.
  
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a healthcare office.
  
- I confirm I am not experiencing any of the following symptoms of COVID-19 listed below:
  - \*Fever                      \*Dry cough                      \*Sore throat
  - \* Runny nose              \*Shortness of breath        \*Loss of taste or smell
  
- I understand travel increases risk of contraction and transmitting COVID-19 virus. I verify that I have NOT in the past 14 days traveled: 1) outside the US to countries that have been affected by COVID-19 or 2) Domestically within the US by commercial airline, bus, or train.

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION. I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

**To be completed by patient (or patient's representative if the patient is a minor or is physically or legally incapacitated)**

Patient's Name: \_\_\_\_\_

Date of Consent: \_\_\_\_\_

Signature of Patient or Representative: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_