# COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO), and that new information is being learned constantly. I also 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 (initial in all places provided)***

| | Initial here |
|---|---|
| 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 confirm I am not experiencing, and will inform you if I ever in the future experience, any of the following symptoms of COVID-19: fever, dry cough, sore throat, shortness of breath, runny nose, loss of taste or smell. | _____ |
| I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT traveled in the past 14 day. I will inform you in the future if I do travel outside of the United States to countries that have been affected by COVID-19, or travel domestically within the United States by commercial airline, bus, or train. | _____ |
| 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 have been offered a copy of this consent form. | _____ |

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 in this office for my present condition and for any future condition(s) for which I seek care from this office.

Patient Name: ________________________________

Signature: ____________________________________ Date: ____________________