# COVID-19 Patient Risk & Treatment Informed Consent

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, confirm that I am voluntarily opting to come into the office for an evaluation, treatment or procedure that is not urgent and not medically necessary. In addition, I am giving my consent to receive an elective aesthetic procedure(s) from Artistry Aesthetics during the COVID-19 outbreak.**

**Patient Initials Required on Each Line:**

\_\_\_\_\_ **I understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization.** I further understand, based on what is currently known about COVID-19, spread is thought to occur mostly from person-to-person via respiratory droplets among close contacts. I understand that close contact can occur from being within approximately 6 feet of someone with COVID-19 for a prolonged period of time or by having direct contact with infectious secretions from someone with COVID-19.

\_\_\_\_\_ **I understand that as a result, federal and state health agencies recommend social distancing.**I recognize that the Dr’s Farley and all the staff at Artistry Aesthetics are closely monitoring this fluid situation and have, and will continue, to put in place reasonable preventative measures per the recommendations of the Center for Disease Control and other health authorities, aimed to reduce the spread of COVID-19.

\_\_\_\_\_ **I understand, given the nature of the virus, there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with any elective office visits, treatment, or procedures.**

\_\_\_\_\_ **I understand that all travelers arriving from a country or region with widespread ongoing transmission, as outlined by the CDC, should stay home for 14 days to practice social distancing and monitor to their health after their arrival.**

\_\_\_\_\_ **I confirm that I have not, nor to the best of my knowledge have I been exposed to anyone who has, traveled outside the country or to/from a region with widespread ongoing transmissions of COVID within the last 3 weeks (21 days).**

\_\_\_\_\_ **I confirm, to the best of my knowledge, that I have not had close contact with an individual diagnosed with COVID-19 in the past 14 days.**

**\_\_\_\_\_ 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 (a false negative) or I may have contracted COVID after the test.** I understand that carriers of COVID-19 may not show symptoms but may still be highly contagious—an asymptomatic carrier. I understand that if I am an asymptomatic carrier, proceeding with this elective office visit, treatment, or procedure can lead to a higher chance of complication and death.

\_\_\_\_\_ **I understand that due to the unknowns of this virus, the number of other patients that have been in the practice and the nature of the procedures performed here, that I have an increased risk of contracting the virus by being in the practice and by receiving treatment in the practice.** I also understand that under the CDC guidelines, do not recommend proceeding with any treatment that is non-essential at this time.

\_\_\_\_\_ **I understand that the CDC guidelines do not recommend proceeding with any treatment that is non-essential at this time and that the treatment I am receiving is NOT a medical emergency.** It is an elective treatment.

\_\_\_\_\_ I understand that dental procedures have the potential to include aerosol-generating procedures as well as anticipated splashes and sprays, which are some of the ways that COVID-19 can be spread. **I confirm that I have not had a dental procedure within the last 14 days.**

\_\_\_\_\_ **I understand that the symptoms listed below are representative of COVID-19 and** **I confirm that I do not display or currently have any of these symptoms:**

• Fever • Cough • Tiredness • Chest Pain • Muscle Aches

• Chills • Sore Throat • Headache • Shortness of Breath/Trouble Breathing

• Loss of Taste or Smell

\_\_\_\_\_ **I understand that possible exposure to COVID-19 before/during/after my office visit, treatment, or 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. In addition, after my elective office visit, treatment, or procedure, I may need additional care that may require me to go to an emergency room or a hospital.

\_\_\_\_\_ **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 office visit, treatment, or procedure itself.

**CONSENT: I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective office visit, treatment and/or procedure, and I give my express permission for Dr. Farley and all the staff at Artistry Aesthetics to proceed with the same. I have been given the option to defer my office visit, treatment, or procedure to a later date.** **However, 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 office visit, treatment, or procedure.**

**I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE OFFICE VISIT, TREATMENT, OR/AND PROCEDURE.**

#1. Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patients Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I acknowledge that I have previously read, am free to read again at any time, & understand this document. I give my continued consent to receive further treatment with botulinum neurotoxin. **This consent is good for 1 year ONLY (January to December) & must be renewed in January of every New Year.**

#2. Patients Sig\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#3. Patients Sig\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#4. Patients Sig\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#5. Patients Sig\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#6. Patients Sig\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#7. Patients Sig\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#8. Patients Sig\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#9. Patients Sig\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

mmf 5.2020