SUNSET

COSMETIC SURGERY

COVID-19 PATIENT CONSULTATION/TREATMENT CONSENT

COVID-19 RISK INFORMED CONSENT

I _____ (patient name) understand that I am opting for an elective consultation, pre-op/postop appointment, treatment, procedure or surgery 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 has been responsible for many cases of severe illness & deaths around the world. This virus is transmitted airborne, by touching surfaces, and by person-to-person contact, and, as a result, federal and state health agencies recommend social distancing. Currently, there is neither a cure nor a vaccine for the disease and, therefore, I as a person wanting to have surgery/treatment, must consider the risks before proceeding.

I recognize that Dr. or RN _____ and all the staff at Sunset Cosmetic Surgery and 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/surgery. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure/surgery, and I give my express permission for Dr. or RN _____ and all the staff at Sunset Cosmetic Surgery and to proceed with the same. 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, if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment/procedure/surgery can lead to a higher chance of complication and death.

Please Initial each section as you read and agree:

_____ I attest that neither I, nor anyone else who I have close contact with have tested positive for Covid-19, or have been diagnosed by physicians to have had severe upper respiratory illness within the last 2 months.

_____ I attest that within the last 2 weeks, (including today) I have not had persistent severe fever (>100.4F), cough, severe shortness of breath, & loss of smell & taste, night sweets, & I have not sought medical treatment for these symptoms.

_____ I understand that despite Sunset Cosmetic Surgery and Dr. Svehlak and Dr. Yamini's best efforts, the risk of contracting Coronavirus exists, and cannot be controlled by their staff and facility. Therefore, I hold my surgeon, staff, and the office of Sunset Cosmetic Surgery harmless if I test positive for COVID-19 and/or develop symptoms of its illness at any time.

_____ I understand and accept the risk that any elective consultation, treatment, procedure or surgery might alter my immunity and possible affect my ability to test positive for COVID-19 and/or develop symptoms of its illness at any time.

_____ I understand that, even if I have been tested negative for COVID-19, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test. I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment/procedure/surgery can compound my overall risk.

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_____ I understand that possible exposure to COVID-19 before/during/after my elective consultation, treatment, procedure or surgery treatment/procedure/surgery 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 and the 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 treatment/procedure/surgery, I may need additional care that may require me to go to an emergency room or a hospital that can potentially expose me to hospital germs including COVID-19.

_____ 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/surgery itself.

_____ I understand that there may be costs associated with diagnosing and treating the COVID-19 infection and I will be responsible for these additional costs

_____ I understand that I may suffer loss of income and time off from work if I am diagnosed with COVID-19

I have been given the option to defer my treatment/procedure/surgery 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 treatment/procedure/surgery.

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

_____ _____

Print Name Date

_____ _____

Signature Date

_____ _____

Witness Print Name Date

_____ _____

Witness Signature Date

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