Informed Consent To Treat
(Spring 2020, COVID-19)

I understand that the Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). 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 am informed that you and your co-workers have implemented preventative measures intended to reduce the spread of COVID-19 in the healthcare office setting. However, given the nature of the virus, I understand there may be an inherent risk of becoming exposed to COVID-19 by proceeding with this treatment.
- 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 understand that I will be asked basic health questions related to COVID-19 symptoms prior to treatment, and may have my temperature or O2 saturation levels assessed.
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you at your offices to proceed with providing care.
- I agree to notify the office immediately if I develop any symptoms commonly associated with COVID-19.
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:

Fever	Shortness of breath	Difficulty breathing
Dry cough	Runny nose	Dry cough
Loss of taste or smell		

- I understand travel (especially to/through areas of high transmission) increases my risk of contracting and transmitting the COVID-19 virus. I will notify this office prior to my appointment if I have traveled in the last 14 days (commercially within the US by plane, train, or bus; or outside the US) to determine if delaying the appointment while safe-isolating for 14 days is in the best interest of mutual health and safety.
- I have been offered a copy of this consent form.

I knowingly and willingly consent to the treatment with full understanding and disclosure of risks associated with receiving care during the COVID-19 pandemic. I confirm that all of my questions related to this consent form have been answered to my satisfaction.

I have read, or have had read to me, the above COVID-19 Risk informed consent to treat information.

I appreciate that it is not possible to consider every complication to care. I agree with current recommendations to receive care as deemed appropriate for my circumstance. I intend this consent to cover the entire course of care for my present condition and future conditions unless otherwise specified. I can change my consent to treat by doing so in writing prior to that treatment commencing.

Patient signature: _____ Date: ____/_____/_____

Parent/guardian signature: _____Date: ____/_____/_____