SPRING STREET DERMATOLOGY

Patient Consent Form

PMS ID: Sex: DOB: Phone: MRN:

PATIENT INFORMATION				
LAST NAME		FIRST NAME		M.I.
SSN	DATE OF BIRTH	SEX	MRN	
STREET ADDRESS				
STREET ADDRESS CONTD.				
CITY		STATE	ZIP CODE	
HOME PHONE	CELL PHONE		EMPLOYER NAME	

COVID-19 Consent

COVID-19 INFORMED CONSENT

I understand that I am opting to appear for a visit that may not be urgent and may be elective.

I also understand that the novel coronavirus (SARS CoV2) causes COVID-19, a disease that has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact and current indications show that the virus is spread by direct contact with droplets from an infected person (which may persist in the air for hours after release) or by touching an infected surface, then touching your face; and, as a result, federal and state health agencies recommend social distancing as one measure to reduce transmission. I recognize that my physician and all of the Spring Street Dermatology staff are closely monitoring this situation and have put in place reasonable preventive measures aimed to reduce the spread of COVID-19 that follow state and federal guidelines. 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 visit. I hereby acknowledge and assume the risk of potentially becoming infected with COVID-19 through this visit and any subsequent visit. I give my express permission to and request that my physician and all the staff at Spring Street Dermatology to proceed with the same.

I understand that, even if I have been tested for COVID-19 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 possible exposure to COVID-19 before/during/after my visit 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 treatment/procedure/surgery, I may need additional care that may require me to go to an emergency room or a hospital which may further increase my exposure to the coronavirus.

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 acknowledge that my health care provider has discussed with me not only the most usual and frequent risks and complications of my visit and any procedure, but also the potential risk and benefits of delaying the proposed visit and/or procedure.

I believe that my visit is medically appropriate and permissible under the government executive orders. I understand it is ultimately my decision and I have been given the option to defer my visit to a later date. I was given enough time to read this information and to decide whether I should or should not appear for my visit, as well as an opportunity to ask any questions in connection with the information contained in this Informed Consent. I do not have any further questions and I voluntarily agree to proceed with my visit. I understand all the potential risks, including but not limited to the potential short-term complications related to COVID-19, and I would like to proceed with my visit.

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

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Patient / Agent / Guardian Signature