PeposeVision
INSTITUTE

Name of patient: _____

Patient date of birth: _____

Date of Visit: _____

Informed Consent: COVID-19

I understand that I am consenting to an examination/treatment/procedure that is not urgent or emergent.

I understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I also understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact, and as a result, federal and state health agencies recommend social distancing. I understand that my doctor has put in place reasonable safety measures to reduce the spread of COVID-19.

I understand that even if I have received a negative COVID-19 test result, the test may have failed to detect the virus, or I may have become infected after I took the test. I understand that even if I do not have any symptoms, I may have a COVID-19 infection, and that having an examination/treatment/procedure may lead to a higher chance of complication and death.

I understand that exposure to COVID-19 before, during, and after my examination/treatment/procedure may result in a positive COVID-19 diagnosis, extended isolation, additional tests, and hospitalization, up to and including, treatment in intensive care (ICU), short- or long-term intubation, other complications, and even death. I also understand that COVID-19 may cause other risks, some of which may not be known at this time.

I understand that this examination/treatment/procedure may put me at increased risk for becoming infected with COVID-19. By signing this consent form I accept that risk and give my permission to proceed with the examination/treatment/procedure for which I am scheduled or which I give approval for during the course of my appointment.

I have been given the choice to have my examination/treatment/procedure at a later date. I understand the potential risks of delaying and want to proceed.

I have read this consent or someone has read it to me. This consent shall be valid for one year after signing unless revoked in writing by patient.

Signature: _____ Patient _____ Date

Signature: _____ Witness (Print Name) _____ Signature

SKF:5/4/2020