

## COVID-19 Risk Informed Consent

I \_\_\_\_\_ understand that I am opting for an elective treatment that is non urgent and elective/not 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 is believed to be spread by person-to-person contact: and, as a result, federal and state health agencies recommend social distancing. I recognize that Dr Elizabeth McCorkle is closely monitoring this situation and has put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand that there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment/procedure. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure and I give my express permission for Dr Elizabeth McCorkle 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-19 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 can lead to a higher chance of complication and death.

I understand that the possible exposure to COVID-19 before/during/after my treatment/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 treatment/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 risk, 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 itself.

I have been given the option to defer my treatment/procedure to a later date. However, I understand all of 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.

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

Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_