

Split Rock Aesthetic Patient Informed Consent Covid-19

I _____ understand that I am opting for an elective treatment/procedure 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 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 Split Rock medical staff is carefully 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. **I hereby** acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment, and I give my express permission for the Split Rock medical staff 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 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 can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before/during/after my treatment 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 intubation, other potential complications, and the risk of death. In addition, **after my elective treatment**, 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 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 itself.

I have been given the option to **defer my treatment** 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**.

I understand that I am **personally responsible** for complying with appropriate **recommendations** including, but not limited to, proper PPE, Split Rock Medical Aesthetics safety protocols, pre & post treatment guidelines and have **honestly answered** the pre-treatment screening questions.

I will not hold Split Rock Aesthetics liable if I contract COVID-19 after my elective procedure.

I understand the explanation and have no more questions and consent to the procedure.

Patient Signature _____

Date _____

Split Rock Aesthetic Staff _____

Date _____

Adapted from ASPS Informed Consent - COVID-19 RISK document.