INFORMED CONSENT AND RELEASE – COVID-19 RISK

I _____ **(please print patient's name here)** understand that I am opting for an elective treatment/procedure which 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 spread by person-to-person contact but that it is impossible to determine who has it and who does not, given the current limits in virus testing and its long incubation period during which carriers of COVID-19 may not show symptoms and still be highly contagious. As a result, federal and state health agencies recommend my social distancing of at least 6 feet away from other people at all times and my wearing a mask or similar face covering when I'm outside of my own residence.

I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:

- Fever or Chills or Repeated Shaking
- Shortness of Breath
- Dry Cough
- New Loss of Sense of Taste/Smell
- Runny Nose or Sore Throat
- Muscle Pain
- Bluish Lips
- Persistent Pain or Pressure in the Chest
- Headache

_____ **(Patient's Initials signifying absence of all above-listed symptoms)**

I understand that public travel may significantly increases my risk of contracting and transmitting COVID-19. I verify that, within the past 14 days I have not traveled: (1) outside the continental United States; and (2) domestically within the United States by commercial airline, bus, or train within the past 14 days. I understand that the CDC recommends self-quarantining for at least 14 days if I have been exposed to anyone who has COVID-19 or, in some instances, been in contact with persons who have traveled by air, bus, or train. I verify that I have not been self-quarantining within the last 14 days due to any such exposure or contact and acknowledge that my maintaining such recommended social distance is impossible during my treatment/procedure and that my wearing a mask or face covering during my treatment/procedure may be impractical or not allowed in order for me to undergo the treatment/procedure.

I recognize that Dr. Tina West and The West Institute staff are using their reasonable efforts to closely monitor this COVID-19 situation as it pertains to providing their in-office medical and other treatments/procedures/services and have put in place in The West Institute's internal areas reasonable preventative measures aimed at reducing the spread of COVID-19 for their patients and staff while they are within The West Institute's internal areas.

However, given the nature of COVID-19, I understand that, regardless of such efforts by Dr. West and her staff, there is an inherent risk of becoming infected with COVID-19 due to my traveling to The West Institute and proceeding with this elective treatment/procedure. I hereby acknowledge and assume the risk of, and release Dr. Tina West and The West Institute staff from all liability as a result of, my becoming infected with COVID-19 and such infection's subsequent consequences as a result of my coming to The West Institute and undergoing this elective treatment/procedure/surgery. I also give my express permission for Dr. West/Chelsea Heidenberger/Amy Gawler and The West Institute staff to proceed with the same.

_____ **Patient Initials**

[*This Informed Consent Form Continues on Next Page Which Requires Patient's Signature*]

I understand that even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect COVID-19 or I may have contracted COVID after the test including during my traveling to The West Institute to be treated today or hereafter. I further understand that, if I have a COVID-19 infection or contract it as a result of coming to The West Institute, and even if I do not have any symptoms for the same, proceeding with this elective treatment/procedure and returning to The West Institute for any follow-up examination can lead to a higher chance of complication and/or death from COVID-19. I also understand that 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 Unit 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 understand that I may need additional care that may require me, at my own expense, 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/procedure itself. I have been given the option to defer my treatment/procedure to a later date.

Having been informed of the proceeding information, I understand and/or acknowledge all of the potential risks including, but not limited to, the potential short-term and long-term complications related to COVID-19, known or unknown, and I would still like to proceed with my desired treatment/procedure.

I UNDERSTAND THE FOREGOING INFORMATION, ACKNOWLEDGE THE RISKS, AND HAVE NO MORE QUESTIONS AND CONSENT TO THE TREATMENT/PROCEDURE.

Signature: _____

Please Print Name: _____

Patient Name [or Name of Person Authorized to Sign for Patient]

Please Print the Date/Time: _____

WITNESS:

Signature: _____

Please Print Name: _____

Witness Name

Please Print the Date/Time: _____