

COVID-19 RISK INFORMED CONSENT

I _____ (patient name) understand that I am opting for an elective treatment/procedure that is not urgent and is 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; and, as a result, federal and state health agencies recommend social distancing.

I recognize that Dr. Patt and all the staff at New Look Houston are closely 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/procedure, and I give my express permission for any and all staff at New Look Houston to proceed with the same.

I hereby acknowledge that I have either been tested negative for COVID-19, or I have not had any symptoms for COVID-19 at the time of the treatment/procedure. I further understand it is my responsibility to let New Look Houston and to reschedule my treatment/procedure in the event that I feel any symptoms or test positive for COVID-19. I understand that New Look Houston will not charge any no show fees for late cancellations of any potential COVID-19 related incidents.

I have been given the option to defer my treatment/procedure 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 treatments/procedures going forward.

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

Patient or Person Authorized to Sign for Patient

Date