COVID-19 INFORMED CONSENT AGREEMENT

☐ I, the undersigned patient, consent to an in-person consultation and/or to have David Stephens, MD and/or his/her staff (hereinafter collectively "David Stephens, MD") perform medical procedures, whether regarded as necessary, elective or aesthetic, during the time of the COVID-19 pandemic and after. I understand in-person consultations and/or having my procedure performed at this time, despite my own efforts and those of David Stephens, MD, may increase the risk of my exposure to COVID-19. I am aware that exposure to COVID-19 can result in severe illness, intensive therapies, extended intubation and/or ventilator support, life-altering changes to my health, and even death. I am also aware of the possibility that the procedure itself, whether performed in David Stephens, MD office or in a hospital, may result in a more severe case of COVID-19 than I might have had without the procedure.

☐ I also understand in-person consultations and/or having my procedure performed at this time increases the risk of my transmission of COVID-19 to my Doctor. This virus has a long incubation period, there may be as yet unknown aspects of its transmission, and I realize that I may be contagious, whether or not I have been tested or have symptoms. To reduce the possibility of COVID-19 exposure or transmission David Stephens, MD office, I accept that my David Stephens, MD will implement infection-control procedures with which I must comply, before, during and after my consultation and/or procedure, for my own protection as well as that of David Stephens, MD. I understand my cooperation is mandatory, whether or not I personally feel such COVID-19 procedures and/or preventive measures are necessary.

☐ I have informed David Stephens, MD of any COVID-19 testing I or any person living with me during the past 14 days has received, as well as the results of that testing, and if I am tested between now and the date of my procedure, I will immediately provide the results of that testing to David Stephens, MD. I understand that David Stephens, MD may require that I be tested, possibly at my own expense and regardless of any prior testing, and that the results of that testing must be satisfactory to David Stephens, MD, before I may receive my procedure.

☐ I confirm neither I nor any individual living with me has any of the COVID-19 symptoms listed by the Centers for Disease Control https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID19-symptoms.pdf, which website I have consulted; neither I nor any individual living with me during the past 14 days has experienced any such symptoms; and that I and all persons living with me for the past 14 days have practiced all personal hygiene, social distancing and other COVID-19 recommendations contained within all governmental orders issued by my city and state. I understand I must honestly disclose this information to avoid putting myself and others at risk.

☐ All topics above have been discussed with me, and all my questions have been answered to my satisfaction. Being fully informed, I accept the risk of COVID-19 exposure and I will bear the cost of any COVID-19 treatments required. I have been given the opportunity to postpone my in-person consultation and/or procedure until the COVID-19 pandemic is less prevalent, but I choose to have my in-person consultation and/or procedure performed now. If I am the parent, guardian or conservator of the patient, I hold his/her health care power of attorney. I have read this COVID-19 Informed Consent Agreement and am authorized to consent on the patient's behalf.

☐ _____ _____

Patient/Authorized Representative Signature and Initials Print Name & Date **[First encounter]**

☐ _____ _____

Patient/Authorized Representative Signature and Initials Print Name & Date **[Day of procedure]**