

SERENITY MD/MD DIET

INFORMED CONSENT – COVID-19 PANDEMIC

I _____, (PATIENT NAME) _____, (DATE OF BIRTH) _____ understand that I am opting for an elective treatment/procedure/surgery 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 spread by person-to-person contact and accordingly, federal and state health agencies recommend social distancing.

I recognize that the medical providers and staff at Serenity MD/MD Diet are closely monitoring this situation and have put in place reasonable preventive measures targeted to reduce the spread of COVID-19. Given the nature of the virus, however, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment/procedure/surgery.

Accordingly, I acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure/surgery, and I give my express permission for the medical providers and staff at Serenity MD/MD Diet to proceed with the same.

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 the virus or I 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, proceeding with this elective treatment/procedure/surgery can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before/during/after my treatment/procedure/surgery may result in any of 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/surgery, 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 in this Informed Consent, as well as those risks for the treatment/procedure/surgery itself.

I have been given the option to defer my treatment/procedure/surgery 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/surgery. I acknowledge that I have been offered a copy of this consent form.

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

Printed Patient Name

Signature of Patient

Date

Practice Representative – witness

Signature of Provider (Supervising Physician Dr. Roland Fuertez)

OFFICE USE ONLY

FEVER _____ YES _____ NO

COVID-19 SCREENING QUESTIONS _____ NEGATIVE