

## COVID-19 INFORMED CONSENT AGREEMENT

---

**Risk of Exposure.** I, the undersigned individual, consent to an in-person office visit and/or to have my Doctor and/or his/her staff (hereinafter collectively “my Doctor”) 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 my Doctor, 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 my Doctor’s office or in a hospital, may result in a more severe case of COVID-19 than I might have had without the procedure.

**Infection Control Procedures.** I also understand in-person office visits 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 at my Doctor’s office, I accept that my Doctor will implement infection-control procedures with which I must comply, before, during and after my office visit and/or procedure, for my own protection as well as that of my Doctor. I understand my cooperation is mandatory, whether or not I personally feel such COVID-19 procedures and/or preventive measures are necessary.

**Testing.** I have informed my Doctor 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 office visit and/or procedure, I will immediately provide the results of that testing to my Doctor. I understand my Doctor 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 my Doctor, before I may receive my procedure and/or have my next in-person office visit.

**Symptoms.** I confirm neither I nor any individual living with me has any of the COVID-19 symptoms listed by the Centers for Disease Control here: <https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID19-symptoms.pdf>. 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.

**My Consents.** 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 office visit and/or procedure until the COVID-19 pandemic is less prevalent, but I choose to have my in-person office visit 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.

\_\_\_\_\_  
*Individual/Patient/Authorized Representative Signature and Initials*

Date \_\_\_\_\_

Print Name \_\_\_\_\_



**Notice and Disclaimer.** Medical information changes constantly. This COVID-19 Informed Consent Agreement sets forth the current recommendations of The Aesthetic Society, is provided for informational purposes only, and does not establish a new standard of care. June 2, 2020