COVID-19 Pandemic Orchidia Medical Group Treatment Consent Form

I _____, knowingly and willingly agree to authorize and give my consent to have elective procedure, or aesthetic treatment(s) performed on me during and or immediately thereafter the COVID-19 Coronavirus pandemic. While the State/Commonwealth of _____ may have relaxed their prior regulatory mandated shutdown of elective procedures, I still elect to proceed.

I have been afforded the voluntary opportunity to consult with any/all medical providers of my choosing, and I have chosen to elect to proceed.

Patient's Initial's _____

I understand the COVID-19 Coronavirus has a long incubation period (approximately 14 days) during which carriers of the virus may not show symptoms and may still be highly contagious. It is incredibly difficult to determine who has the virus and is contagious given the current limits in virus testing.
Patient's Initial's _____

I have been made aware of the CDC guidelines that under the current pandemic, that all non-urgent medical care is not recommended. I am taking all necessary precautions to limit the risk of virus transmission, however I understand there are no guarantees that you may be subject to transmission of the COVID19 Coronavirus by electing to proceed with your treatment(s).

Patient's Initial's _____

I, confirm that I am not presenting or have not presented for the past 7 days any of the following symptoms of COVOID-19 listed below:

Fever	Dry Cough
Shortness of Breath	Runny Nose
Loss of Taste of Smell	Sore Throat

Patient's Initial's _____

I, confirm that none of the residents or guests of where I have been residing or personally visiting for the past 7 days are not presenting or have previously presented for the past 7 days any of the following symptoms of COVOID-19 listed below:

Fever

Shortness of Breath

Loss of Taste or Smell

Dry Cough

Runny Nose

Sore Throat

Patient's Initial's _____

I understand that person to person contact increases my risk of contracting and transmitting the COVID-19 Coronavirus, and the CDC recommends social distancing with a minimum of at least 6 feet at all times. I understand this is not possible with our treatments at Orchidia medical Group.
Patient's Initial's _____

I verify that I have not traveled outside the United States in the past 14 days regardless of whether or not they have been affected by COVID-19.
Patient's Initial's _____

I verify that I have not traveled domestically within the United States by commercial airline, public bus, or public train within the past 14 days.

Patient's Initial's _____

I have been given the opportunity to review all of the stated conditions in this release, have had the voluntary opportunity to review this document with any of my personal healthcare and/or legal advisors, and that I hereby grant my voluntary permission and elect to proceed with my requested treatment.

Patient's Initial's _____

I have taken and will take every necessary precaution to protect me, and has advised me of any/all associated risks of having a cosmetic/surgical treatment, and I have elected to proceed.

Patient's Initial's _____

Name of Patient _____ Date_____

Signature of Patient: _____ Date: _____

Staff Witness Name:_____ Date_____

Signature of Staff Witness :_____ Date_____