Refine
BY FARRELL
Suzanne Arcuni Farrell, APRN

COVID-19 RISK INFORMED CONSENT

I _____ (patient name) understand that I am opting for an elective treatment/procedure that is not urgent and not 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 Suzanne Farrell, APRN at Refine By Farrell, LLC is closely monitoring this situation and has 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 Suzanne Farrell, APRN at Refine By Farrell 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 for the same, proceeding with this elective treatment/procedure may lead to a higher chance of complications. I understand that possible exposure to COVID-19 before/during/after my treatment/procedure may result in the following: a positive COVID-19 diagnosis, extended

quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, and other potential complications, and the risk of death. In addition, after my elective treatment/procedure I may need additional care that may require me to go to an emergency room or a hospital.

I understand that COVID-19 and/or vaccination against 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 herein, as well as those risks for the treatment/procedure itself. This may include but is not limited to allergic reaction, swelling, nodules and/or infection in treated and/or non-treated areas. These adverse reactions could develop at any time after treatment, either before or after vaccination. I agree to inform Suzanne Farrell, APRN of any unintended reactions or side effects.

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 treatment/procedure.

_____(patient signature)

_____(provider signature)

DATE:_____