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 believed to spread by person-to-person contact. I recognize that Suzanne Farrell, APRN at Refine By Farrell, LLC has put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, 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, 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, quarantine/self-isolation, additional tests, possible medical therapy, and other potential complications

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 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:_____