Informed Consent for Health Care / Medical Services During the COVID-19 Pandemic

1. By signing this Informed Consent for Health Care or Medical Services During the COVID-19 Pandemic, I consent to receive health care or medical services from [Practice Name] and potentially undergo elective surgery and invasive procedures during the COVID-19 pandemic.

2. I understand that the novel coronavirus, COVID-19, was declared a Public Health Emergency by the State of Virginia as well as a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread most frequently by person-to-person contact, and as a result, federal and state health agencies recommend social distancing and the use of personal protective equipment (PPE). I understand that this office has put in place reasonable safety measures to help reduce the spread of COVID-19 including the use of PPE. I agree to immediately notify office personnel of any concerns I have regarding the COVID-19 precautionary steps taken by [Practice Name].

3. I understand that even if I have received a negative COVID-19 test result, the test may have failed to detect the virus, or I may have become infected after I took the test. I understand that even if I do not have any symptoms, I may have a COVID-19 infection, and that visiting a medical practice to receive health care or medical services or undergo surgery or an invasive procedure can lead to a higher chance of complication and death.

4. I understand that exposure to COVID-19 before, during, and after receiving my health care or medical services or undergoing surgery or an invasive procedure may result in the following: a positive COVID-19 diagnosis, extended isolation, additional tests, and hospitalization, up to and including the need for treatment in intensive care (ICU), short-term or long-term intubation, other complications, and death. I also realize that there is no way to determine beyond a reasonable doubt, if I become COVID-19 positive, where I actually contracted the virus. I further understand that, after receiving health care or medical services or undergoing surgery or an invasive procedure, I may need additional care that may require that I go to an emergency department or hospital.

5. I understand that COVID-19 may cause additional risks, some of which may not be known at this time. I understand that receiving health care or medical services or undergoing surgery or an invasive procedure may put me at increased risk for becoming infected with COVID-19 or experiencing medical complications relating to COVID-19. By signing this consent form, I accept that risk and give my permission to proceed at this time with these health care or medical services and/or undergo surgery or an invasive procedure.

I have read this consent, or someone has read it to me. I fully understand the informed consent related to COVID-19.

_____ _____

Patient Signature (or person authorized to sign for patient) Date

_____ _____

Witness Date