# PLASTIC SURGERY VEGAS COVID-19 INFORMED CONSENT

**CERTIFICATIONS (Please initial)**

___ I currently do not have any flu-like symptoms.

___ I have not been diagnosed with or tested positive for COVID 19.

___ I have not been in close contact with anyone who has been diagnosed with COVID 19

I_____understand that I am opting for evaluation and possible treatment that is not urgent and may not be medically necessary. I am aware that Plastic Surgery Vegas is following state and federal guidelines to prevent the spread of the coronavirus.

I further understand that COVID-19 is contagious and is believed to spread by person-to-person contact; and, as a result, federal and Nevada state health agencies have recommended social distancing. I recognize that the providers and staff of Plastic Surgery Vegas have put in place reasonable preventative measures aimed to reduce the spread of COVID-19 which I agree to comply with. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this evaluation and possible treatment, and I give my express permission for the providers and staff of Plastic Surgery Vegas to proceed with the same.

I understand that possible exposure to COVID-19 before/during/after my evaluation and treatment may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, and possible need for hospitalization. In addition, after my evaluation and possible treatment, I may need additional care that may require me to go to an emergency room or a hospital. I understand that 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.

I have been given the option to defer my treatment/procedure/surgery 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/surgery.

**I UNDERSTAND THE EXPLANATION ABOVE AND HAVE NO MORE QUESTIONS AND CONSENT TO EVALUATION AND TREATMENT IF DEEMED APPROPRIATE**

| | |
|---|---|
| Name | Date/Time |
| Signature | Witness |