

Informed Consent for COVID-19 Risk

Last Name _____ First Name _____

I understand that I am requesting an elective procedure or service that is not urgent and may not be 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 may be transmitted by asymptomatic individuals by coughing, sneezing or simply breathing/talking. It also may be transmitted by touching contaminated surfaces followed by hand to face contact. As a result, federal, state and local health agencies have recommended or ordered shelter at home, social distancing, masks, hand hygiene and other measures to reduce the chance of transmission of this virus.

I recognize that Dr. Charles B. Christian, Jr. and the staff at Inside Outside Wellness Center & Medical Spa are closely monitoring this situation and have put in place reasonable precautions required by the [CDC](#), [Governor Abbott](#), [Texas Department of State Health Services](#), [Texas Medical Board](#), [San Antonio Metropolitan Health District](#) and [Texas Medical Liability Trust](#) (our Malpractice Carrier) to reduce the spread of COVID-19 during your visit.

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 procedure or service. The procedure or service I am requesting may likely not allow social distancing; therefore, I hereby acknowledge and assume the increased risk of becoming infected with COVID-19 through this elective procedure or service and I give my express permission for Dr. Christian and his staff to proceed with the same. Although Dr. Christian and staff have been and are asymptomatic, there is no guarantee that they are not asymptomatic carriers. Likewise even though I am asymptomatic I might be an asymptomatic carrier.

I understand that, even if I have been tested for COVID-19 and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID-19 after the test and that antibody testing may be unreliable and may or may not indicate immunity or previous exposure to this particular virus.

I understand that possible exposure to COVID-19 before/during/after my procedure or service is increased and may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests/contact tracing, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. The risks appear to be more severe in persons >65 years & those with diabetes, hypertension or obesity.

I have been given the option to defer my procedure or service 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 procedure or service.

When I arrive for my appointment I agree to a temperature check and screening for COVID-19 symptoms and will follow the precautions required for this procedure or service. I have no more questions and consent to the procedure or service.

Client Signature

Date