COVID SCREENING QUESTIONS

Are you experiencing or have experienced in the last 2 weeks: fever over 100F, cough, shortness of breath, difficulty breathing, sore throat, chills, repetitive shaking and chills, severe headaches, diarrhea, severe muscle pains, loss of taste or smell, close contact with anyone with known COVID-19. If yes, please contact your primary care doctor for treatment. Your appointment today will be rescheduled.

COVID-19 IN OFFICE VISIT CONSENT

1. I _____ (patient name) 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.

2. I recognize that my physician, Dr. Tracy Katz or Dr. Jennifer Deaver Peterson, and all the staff at The Pearl Dermatology are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19 including those outlined in the Texas Medical Board and Chapter 241 of the Texas Health & Safety Code, shall post a COVID-19 Minimum Standards of Safe Practice Notice (COVID-19 Notice). However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of entering a medical office and/or proceeding with any in office treatment/procedure/surgery.

3. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through entering a medical office and/or any in office elective treatment/procedure/surgery, and I give my express permission for my physician, Dr. Tracy Katz or Dr. Jennifer Deaver Peterson, and all the staff at The Pearl Dermatology to proceed with the same.

4. I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms of COVID-19, proceeding with any elective treatment/procedure/surgery can lead to a higher chance of complications.

5. I understand that possible exposure to COVID-19 before/during/after entering into the medical office and/or receiving any in office treatment/procedure/surgery may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, 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.

6. In addition, after entering into a medical office and/or receiving any in office elective treatment/procedure/surgery, 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, as well as those risks for the treatment/procedure/surgery itself*.

7. I understand that I have the option to defer my in-office visit/treatment/procedure/surgery to a later date, especially if it is nonessential and elective. 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 entering into the medical office and any desired in-office treatment/procedure/surgery*.

8. I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO ENTERING THE MEDICAL OFFICE AND/OR THE PROCEDURE*.

*Any in office procedures and/or surgeries will also require completion of consent forms which are relevant to the procedures being performed.