



COVID-19 PANDEMIC CONSENT

I _____, understand that I am opting for an elective treatment/procedure 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 accordingly, federal and state health agencies recommend social distancing.

I recognize that the medical providers and staff at Aspire Medical Spa are closely monitoring this situation and have put in place reasonable preventive measures targeted to reduce the spread of COVID-19. Given the nature of the virus, however, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment/procedure.

Accordingly, I acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure/surgery, and I give my express permission for the medical providers and staff at Aspire Medical Spa to proceed with the same.

I understand that even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test. I understand that if I have a COVID-19 infection and even if I do not have any symptoms, proceeding with this elective treatment/procedure/surgery can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before/during/after my treatment/procedure/surgery may result in any of 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. In addition, after my 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 in this Informed Consent, as well as those risks for the treatment/procedure itself.

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 acknowledge that I have been offered a copy of this consent form.

I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND
CONSENT TO THE PROCEDURE.

Signature of Patient & Date

Health Questionnaire:

1. Have you traveled in the last 14 days (yes or no)? _____
2. If you have traveled, where did you go? _____
3. Are you currently experiencing any of the following symptoms (yes or no):
 - Cough _____
 - Fever _____
 - Shortness of breath _____
 - Chills _____
 - Lower respiratory illness _____
 - Headache _____
 - Muscle Aches or general feeling of illness _____
 - New olfactory and taste disorder _____
 - Sore throat _____
 - Discoloration to toes or fingers _____
4. Have you been in close contact to a person that has laboratory confirmed COVID-19 in the last 14 days? (yes or no) _____
5. Patient was notified that if any of the above information changes they are to notify Aspire Medical Spa immediately _____ (initials)

Patient signature