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Informed Consent: COVID-19 Risk

I understand that I am consenting to an elective exam/treatment/procedure/surgery that is not urgent or emergent. 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 as a result, federal and state health agencies recommend social distancing. I understand that Dr. Hwang and staff has put in place reasonable safety measures to help reduce the spread of COVID-19.

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 having the elective exam/treatment/procedure/surgery can lead to a higher chance of complication and death.

I understand that exposure to COVID-19 before, during, and after my exam/treatment/procedure/surgery 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. After my elective surgery I may need additional care that may require that I go to an emergency department or hospital.

I understand that COVID-19 may cause additional risks, some of which may not be known at this time. I also understand that this elective exam/treatment/procedure/surgery may put me at increased risk for becoming infected with COVID-19. **By signing this consent form I accept the risks and give my permission to proceed with the exam/treatment/procedure/surgery listed below**.

I have been given the choice to have my exam/treatment/procedure/surgery at a later date. I understand the potential risks of delaying and want to proceed.

I have read this consent or someone has read it to me.

Name of patient: ______________________________ DOB: ____________________

Patient Signature: ______________________________ Date: ____________________

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