Northern Apache County
Special Health Care District

COVID-19 INFORMED CONSENT

I _____ (Patient Name) understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that the Clinic wishes to provide me with information to assist me in making informed choices with regard to my healthcare needs. This includes my understanding and agreement regarding the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult. To proceed with receiving care, I confirm and understand the following (initial next to each statement):

I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to person contact, in which COVID-19 can be transmitted. *(Initials)*_____

I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. *(Initials)*_____

I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care clinic. *(Initials)*_____

I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:

*Fever *Shortness of Breath *Dry Cough *Runny Nose *Sore Throat *Loss of Taste or Smell. *(Initials)*_____

I confirm that I have not been exposed to someone who has tested positive for COVID-19 in the last two weeks. *(Initials)*_____

I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through seeking care and treatment at the Clinic and give my express permission to you and the staff at your offices to proceed with providing care. *(Initials)*_____

I knowingly and willingly consent to the treatment with the full understanding of the risks associated with receiving care during the COVID-19 pandemic. I confirm that all of my questions have been answered to my satisfaction. I have read, or have had read to me, the above COVID-19 Informed Consent Form, and I have had the opportunity to ask questions about the risks involved with obtaining treatment. By signing below, I agree with the current or future recommendation to receive care, and I agree to hold the Clinic harmless if I contract COVID-19. I intend this consent to cover the entire course of care from all providers at the Clinic, including for my present condition and for any future condition(s).

Signature: _____ Witness: _____
Date: _____ Date: _____

SMC.SC.200.19