COVID Attestation and Consent
Innate Beauty Medical Spa

ATTESTATION:

I, _____ (patient name), attest that, in the past three weeks (please CHECK a response per statement:

I have had a fever > 100* F: _____Yes _____ No. If Yes, date of last fever: _____

I understand my temperature will be checked today, and if I have an elevated temperature, I will not receive treatment today, and this appointment will be considered a No-Show: _____Yes _____ No

I have traveled to or from Austin in the past 4 weeks: _____Yes _____ No

I have had a cough: _____Yes _____ No If yes, date of last cough: _____

I have had shortness of breath: _____Yes _____ No

I have had sore throat: _____Yes _____ No

I have had muscle aches: _____Yes _____ No

I have had abdominal pain: _____Yes _____ No

I have had headache: _____Yes _____ No

I have had fatigue: _____Yes _____ No

I have had a skin rash: _____Yes _____ No

I have had loss of taste or smell: _____Yes _____ No

I have had nausea, vomiting, or diarrhea: _____Yes _____ No

I have had discoloration / bruising on my toes: _____Yes _____ No

I have been around someone exhibiting these symptoms within the past 21 days: _____Yes _____ No

I am living with or been in contact with someone who is sick or quarantined: _____Yes _____ No

I have tested positive for COVID-19: _____Yes _____ No. If yes, date positive COVID test: _____

I will notify Dr. Ling / Innate Beauty if I ever test positive for COVID-19: _____Yes _____ No

COVID-19 RISK INFORMED CONSENT:

I _____ (patient name) understand that I am opting for an elective treatment/procedure/surgery 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, as a result, federal and state health agencies recommend social distancing. I recognize that Dr. Shirat Ling and all the staff at Innate Beauty Medspa are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. 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 treatment/procedure/surgery. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure/surgery, and I give my express permission for Dr. Shirat Ling and all the staff at Innate Beauty Medspa 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 for the same, 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 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 herein, as well as those risks for the treatment/procedure/surgery 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 UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE PROCEDURE.. I have been offered a copy of this consent form (patient's initials) _____

_____ _____ _____ _____

Patient or Person Authorized to Sign for Patient Date/Time Witness Date/Time