LEMMON AVENUE
PLASTIC SURGERY & LASER CENTER

**Corona Virus Screening Assessment and Safety Measures**

Within the past 2 weeks have you…

| | |
|---|---|
| been on an airplane? | □ yes □ no |
| travelled outside of Texas? | □ yes □ no |
| had contact with known COVID-19 patient? | □ yes □ no |
| had fever, chills, sore throat, cough? | □ yes □ no |
| Have you been practicing social distancing? | □ yes □ no |
| Have you been tested for the coronavirus? | □ yes □ no |
| What was the result? | □ negative □ positive |

***Do your part:***

Complete this form and all paperwork ***prior*** to your arrival for your appointment. Please email these forms to Shannon@drdeuber.com

Please arrive ***on time*** for your appointment; if you arrive early or late, please wait in your car and contact the practice to alert us of your status. We will work you in when safely possible.

Please arrive wearing a mask that you ***bring from home***. You ***may not*** be admitted for service if you do not have a mask.

Please ***do not*** bring unnecessary companions to your procedure/service. (children will not be allowed to accompany you into our facility). Surgery/laser patients may bring a companion to receive aftercare instructions and to have a ride home;  We will ask that your companion please wait off-site while you are being treated.

Upon your arrival you will undergo a temperature scan by our staff.  If your temperature exceeds 99.6 degrees F, you ***will not*** be permitted to enter our facility.

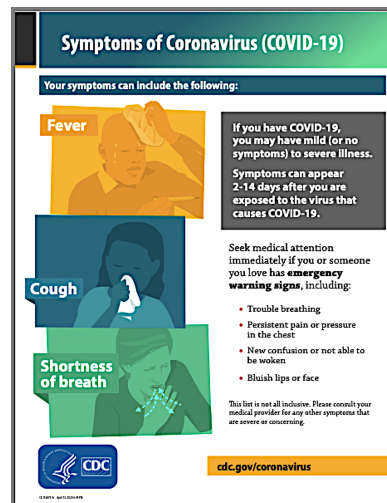
**Thank you for adhering to these instructions during this challenging time.**

# COVID-19 INFORMED CONSENT AGREEMENT

☐ I, the undersigned patient, consent to have Dr Deuber and/or his/her staff (hereinafter collectively "my Doctor") perform medical procedures, whether regarded as necessary, elective or aesthetic, during the time of the COVID-19 pandemic and after. I understand having my procedure performed at this time, despite my own efforts and those of my Doctor, may increase the risk of my exposure to COVID-19. I am aware that exposure to COVID-19 can result in severe illness, intensive therapies, extended intubation and/or ventilator support, life-altering changes to my health, and even death. I am also aware of the possibility that the procedure itself, whether performed in my Doctor's office or in a hospital, may result in a more severe case of COVID-19 than I might have had without the procedure.

☐ I also understand having my procedure performed at this time increases the risk of my transmission of COVID-19 to my Doctor. This virus has a long incubation period, there may be as yet unknown aspects of its transmission, and I realize that I may be contagious, whether or not I have been tested or have symptoms. To reduce the possibility of COVID-19 exposure or transmission at my Doctor's office, I accept that my Doctor will implement infection-control procedures with which I must comply, before, during and after my procedure, for my own protection as well as that of my Doctor. I understand my cooperation is mandatory, whether or not I personally feel such COVID-19 procedures and/or preventive measures to be necessary.

☐ I have informed my Doctor of any COVID-19 testing I or any person living with me during the past 14 days has received, as well as the results of that testing, and if I am tested between now and the date of my procedure, I will immediately provide the results of that testing to my Doctor. I understand my Doctor may require that I be tested, possibly at my own expense and regardless of any prior testing, and that the results of that testing must be satisfactory to my Doctor, before I may receive my procedure.




☐ I confirm neither I nor any individual living with me has any of the COVID-19 symptoms listed by the Centers for Disease Control https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID19-symptoms.pdf, which website I have consulted; neither I nor any individual living with me during the past 14 days has experienced any such symptoms; and that I and all persons living with me for the past 14 days have practiced all personal hygiene, social distancing and other COVID-19 recommendations contained within all governmental orders issued by my city and state. I understand I must honestly disclose this information to avoid putting myself and others at risk.

☐ All topics above have been discussed with me, and all my questions have been answered to my satisfaction. Being fully informed, I accept the risk of COVID-19 exposure and I will bear the cost of any COVID-19 treatments required. I have been given the opportunity to postpone my procedure until the COVID-19 pandemic is less prevalent, but I choose to have my procedure performed now. If I am the parent, guardian or conservator of the patient, I hold his/her health care power of attorney. I have read this COVID-19 Informed Consent Agreement and am authorized to consent on the patient's behalf.

☐ ______________________________ ______________________________

*Patient/Authorized Representative Signature and Initials* Print Name & Date **[First encounter]**

☐ ______________________________ ______________________________

*Patient/Authorized Representative Signature and Initials* Print Name & Date **[Day of procedure]**