THE CENTER FOR DERMATOLOGY CARE

COVID-19 PANDEMIC ESSENTIAL MEDICAL AND TREATMENT CONSENT FORM

I, _____, knowingly and willingly consent to have a medical exam and treatment completed during the COVID-19 pandemic. I understand that this requires me to be in close contact with my doctor and clinical staff in order to be able to examine you appropriately.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. It is impossible to determine definitively who has it and who does not, given the current limits in virus testing.

I further understand that given the current situation, no practice can protect their patients 100% against getting exposed to the virus. There are certain inherent risks associated with a medical exam during an epidemic and I assume full responsibility for personal illness that may result and further release and discharge The Center for Dermatology Care, it's physicians and staff from injury, loss or damage arising out of my visit. By agreeing to be seen, I agree to not hold The Center for Dermatology Care, it's physicians, or any of their associates liable for any potential viral exposure. I understand that a COVID-19 infection can lead to illness, disability, or even death and knowingly take the risk of exposure as I deem my medical exam and appropriate treatments to be essential to the maintenance of my healthcare.

- I confirm I am seeking treatment for a medical condition at The Center for Dermatology Care. _____(initial)

- I confirm that I am not presenting any of the following symptoms of COVID-19 listed below within the last 2 weeks:
    - Fever
    - Shortness of Breath
    - Loss of Sense of Taste or Smell (no previous history)
    - Dry Cough
    - Runny Nose
    - Sore Throat

    _____(initial)

- I understand that current recommendations require that I wear a mask over my nose and mouth, maintain a 6-foot distance from others, and refrain from talking when medical personnel are closer than 6 feet when performing a medical exam or when providing treatments. _____(initial)

Name: _____ Date: _____

Temperature: _____

August 4, 2020