THE CENTER FOR COSMETIC SURGERY & *mediSpa*

DEAN P KANE, MD, FACS, PA
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COVID19 Patient Responsibility and Instructions for COVID19 Safety

Dear Patient, In the interest of SAFETY FIRST, Team Kane wishes for you to understand there have been many modifications in our practice to provide you with a caring, safe and efficacious environment. We hope you understand that these changes are all meant to protect your wellbeing. Please let us know if we can be of any further help. Thank you, Dean Kane, MD, FACS

In order that we may open and provide services to you, you must follow the following Government, Plastic Surgery and Best-in-Care guidelines. Thank you.

1. Make an appointment for your service(s). No Walk-In services available.
2. Please download and complete and send or bring your COVID19 Patient Consent, updated Medical Information: drdeankane.com>patient info>patient forms.
    a. All Patients must read and sign the COVID19 FORMS for EACH office visit.
    b. If it has been more than 1 year since we last saw you, please include: Practice Authorization, HIPAA Acknowledgement, Patient Demographics, Base Medical Data form
3. Please obtain your own temperature at home. If it is more than 100.0 degrees F. Please reschedule and call your PMD for recommendations.
4. Arrive to the Office 15 minutes prior to the schedule appointment time.
5. From your car, call the office to indicate you have arrived and the receptionist will indicate whether we have the proper Patient-Distancing for you to enter the office.
6. Cell phone use will not be allowed in the office.
7. Only the patient can enter the office. ALL family, friends, children, pets and associates must remain outside.
8. All patients must wear a mask and bring your own pen! The patient will be expected to properly wash their hands upon entering the office. Be prepared to have your temperature taken. If more than 100.0 degrees F, you will be offered your options.
9. For patients receiving any services to the face and neck, please wash your face and arrive with no make-up.

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COVID-19 INFORMED CONSENT AGREEMENT

Symptoms of CoronaVirus (SARS-CoV-2 infection) COVID19:

- *Fever (above 100.0 degree F.*
- *Cough: dry or wet*
- *Shortness of breath, chest pain*
- *Muscle pain*
- *Stroke, red spots on skin*

Print Patient Name

Medical Record Number

☐ I, the undersigned patient, consent to have my Doctor 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 remain totally financially responsible for all COVID-19 exposure and complications.

☐ 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.

☐ I will inform the Practice of Dean P. Kane, MD, FACS, PA of any active COVID19 infection and / or testing results which occurred within 14 days of my procedure and agree to proceed to my PMD or healthcare facility for care.

☐ I acknowledge that the Practice of Dean P. Kane, MD, FACS, has made every effort within reason to protect me from contact with and contamination from Corona virus (SARS-CoV-2) recognizing that the protection from and care of this illness is changing and ongoing.

Patient Signature

Date

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Name:_____ Date:_____MR#_____Staff Initials: _____

COVID19 Patient Questionnaire

Dear Patient, In the interest of SAFETY FIRST, Team Kane wishes for you to understand there have been many modifications in our practice to provide you with a caring, safe and efficacious environment. We hope you understand that these changes are all meant to protect your wellbeing. Please let us know if we can be of any further help. Thank you, Dean Kane, MD, FACS

Please answer the following questions in order to best stratify you Corona virus (SARS-CoV-2) carrying or infection potential. This will determine who may receive the current services available at our Practice. Thank you for your understanding.

Y N	Have you been out of the US or Maryland AND quarantined yourself during the past 14 days?
Y N	During the 14 days prior to today or your planned procedure, have YOU had any symptoms of COVID19 (including but not limited to: fever over 100.0 degree F without Tylenol, cough – wet or dry, shortness of breath, loss of taste or smell, loss of appetite, extreme fatigue, eye redness – conjunctivitis) ?
Y N	Have you been within 6 feet of a COVID19 positive individual or group?
Y N	Have you been within 6 feet of an individual who has tested positive for the COVID swab test or COVID19 Antibody test i
Y N	Have you been in contact with any individual with any active illness other than COVID19?
Y N	Do you always wear a mask over you mouth and nose when out of the house?
Y N	Do you have any of the following uncontrolled *added risks*? Over 65 years, high blood pressure, obesity, diabetes, asthma, COPD, on ANY immunosuppressive medication?
	What is your Occupation: _____ Front line worker: healthcare, first responder, grocery/commerce worker
	Your Risk of COVID-19 Exposure is:
Y N	Mild: no symptoms during prior 14 days, no contacts with COVID or non-COVID ill individuals, if tested - it is negative
Y N	Moderate: positive contacts but no symptoms during prior 14 days, if tested – it is negative
Y N	Severe: symptoms, COVID positive test, added risks

Patient signature: _____ Date: _____