THE CENTER FOR COSMETIC SURGERY &

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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*

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 evaluation and 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 that 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 understand that COVID19 vaccination and boosters are recommended.

☐ I will inform my Doctor of any positive COVID-19 testing or symptoms including: ***Fever*** *(above 100.0 degree F or dry/wet* ***Cough*** that I or any person living or working with me developed during the past 14 days. I understand that 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.

☐ 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 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

Notice and Disclaimer. Medical information changes constantly. This COVID-19 Informed Consent Agreement sets forth the modified recommendations of Dean Kane, MD, PA.