Cosmetic and Reconstructive Surgery of the Eye Region
PLASTIC EYE SURGERY ASSOCIATES, PLLC
www.plasticeyesurgery.com

JAMES R. PATRINELY, MD, FACS
CHARLES N.S. SOPARKAR, MD, PhD, FACS
3730 Kirby Drive, Suite 900, Houston, TX 77098
Tel. (713) 795-0705 Fax (713) 807-0630

PERSONAL REGISTRATION INFORMATION

PLEASE PRINT CLEARLY USING BLACK PEN
Please fill out the following information completely.

DATE: _____

PATIENT INFORMATION

NAME:_____AKA:_____DATE OF BIRTH:_____

SOCIAL SECURITY NUMBER:_____M/F:_____MARITAL STATUS:_____

ADDRESS:_____CITY:_____STATE:_____ZIP CODE:_____

OCCUPATION/EMPLOYER:_____DRIVERS LICENSE NO.: _____

GUARANTOR

NAME: _____ RELATIONSHIP: _____

SOCIAL SECURITY NUMBER:_____M / F:_____ MARITAL STATUS: _____

ADDRESS (if different)_____CITY:_____STATE:____ZIP:_____

HOME PHONE:_____WORK PHONE:_____EMPLOYER:_____

EMERGENCY CONTACTS

NAME:_____PHONE #1:_____PHONE #2:_____RELATION:_____

NAME:_____PHONE #1:_____PHONE #2:_____RELATION:_____

INSURANCE

PRIMARY INSURANCE CO:_____PHONE NO:_____
INSURED NAME:_____ INSURED DOB:_____ SS#:_____
PLAN TYPE:_____ GROUP #:_____ INSURED ID#: _____
INSURED DRIVERS LICENSE NO.:_____ RELATIONSHIP TO PATIENT:_____

SECONDARY INSURANCE CO:_____ PHONE NO: _____
INSURED NAME:_____ INSURED DOB:_____ SS#:_____
PLAN TYPE:_____ GROUP #:_____ INSURED ID#:_____
INSURED DRIVERS LICENSE NO.:_____ RELATIONSHIP TO PATIENT: _____

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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Plastic Eye Surgery Associates, PLLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Plastic Eye Surgery Associates, PLLC. I understand that diagnosis or treatment of me by James R. Patrinely, MD and Charles N.S. Soparkar, MD, PhD may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Plastic Eye Surgery Associates, PLLC is not required to agree to the restrictions that I may request. However, if Plastic Eye Surgery Associates, PLLC agrees to a restriction that I request, the restriction is binding on Plastic Eye Surgery Associates, PLLC and James R. Patrinely, MD or Charles N.S. Soparkar, MD, PhD.

I have the right to revoke this consent, in writing, at any time, except to the extent that James R. Patrinely, MD or Charles N.S. Soparkar, MD, PhD with Plastic Eye Surgery Associates, PLLC has taken action in reliance on this consent.

My "*protected health information"* means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Plastic Eye Surgery Associates, PLLC's Notice of Privacy Practices prior to signing this document. The Plastic Eye Surgery Associates, PLLC's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Plastic Eye Surgery Associates, PLLC. The Notice of Privacy Practices for Plastic Eye Surgery Associates, PLLC is also provided in the clinic hallway. This Notice of Privacy Practices also describes my rights and the Plastic Eye Surgery Associates, PLLC's duties with respect to my protected health.

Plastic Eye Surgery Associates, PLLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Plastic Eye Surgery Associates, PLLC's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____

Signature of Patient (or legal representative)

_____

Printed Name of Patient (and legal representative, if applicable)

_____

Date

_____

Description of legal representative's authority

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FINANCIAL POLICY & ASSIGNMENT OF BENEFITS

Thank you for selecting Plastic Eye Surgery Associates, PLLC (PESA) for your care. To prevent any confusion over financial responsibility for medical and surgical services provided, we supply you with the following information:

The patient, guarantor, or the person bringing the patient (if the patient is a minor), is responsible for payment of services at the time of office visit, test, or procedure. Payment may be made by cash, personal check (NSF charge: $30), or credit card (American Express, Discover, VISA, or MasterCard). In the case of divorced parents, the parent bringing the child to the office is responsible for payment at the time of service. Bills provided at each visit contain all the information needed for you to submit requests to your insurance carrier.

If your insurance plan requires a referral from your primary care physician, it is your responsibility to bring the referral with you and present it at the registration desk at the time of your visit. Federal law and insurance contracts require us to ask for your insurance card and driver's license at check in for identification purposes.

PESA CONTRACTED INSURANCE COVERAGE

If you have coverage through an insurance company that has a contract with the doctor you are seeing, we are required to ask for copy of your insurance card and payment of your deductible and/or co-payment at the time of service.

NON-PESA CONTRACTED INSURANCE COVERAGE

If you have coverage through an insurance company that does not have a contract with the doctor you are seeing, we will ask for a copy of your insurance card but payment for services may be due at the time of your visit. We will be happy to communicate with your insurer to possibly provide covered care.

MEDICAID

If you have Medicaid coverage, you must provide a current Medicaid card at the time of your visit. If the card is not available, you must either pay for the visit or reschedule the appointment. If within three months after the visit you receive a retroactive card that covers the date of the visit, payment will be refunded after Medicaid has paid for your visit. You must pay for non-covered services at the time of your visit.

MEDICARE

Office visits to a doctor are covered under Part B of the Medicare program. Medicare pays 80% of their allowable charges after you pay the annual deductible for the calendar year. You are fully responsible for any non-covered services. As a courtesy, if you have supplemental insurance, we will be glad to file this for you.

I have read the above information and agree that regardless of insurance status, I am responsible for the account balance for all services rendered to the individual listed as "patient" below including disclosed, non-covered medical services. Further, I irrevocably assign and transfer all health plan and insurance benefits to Plastic Eye Surgery Associates, PLLC (PESA), authorizing payment to PESA for all benefits payable to "patient" including health plan benefits, ERISA benefits, insurance payments, payments pursuant to the Social Security Act and other medical benefits to which "patient" may be entitled. PESA may pursue collection of such benefits in "patient's" name or in the name of PESA. Finally, I authorize the release of any medical information necessary to process "patient's" claims. A photocopy of this agreement shall be considered as effective and valid as the original.

Signature of Patient: _____ Date: _____

Printed Name of Patient: _____

If applicable, Signature of Guardian or Responsible Party: _____

Printed Name of Guardian or Responsible Party: _____

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ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICE NOTICE

By signing this form, you are agreeing that you have received a copy of the Plastic Eye Surgery Associates, PLLC Privacy Notice, which describes how we use and disclose your health information. You have the right to refuse to sign this Acknowledge, in which case we must document our good faith effort to obtain your acknowledgment and the reason why it was not obtained.

Receipt of Privacy Notice acknowledged by:

_____

Signature of Patient (or legal representative)

_____

Printed Name of Patient (and legal representative, if applicable)

_____

Date

If not patient, then relationship to patient: _____

Patient, Spouse, Legal Representative, or Beneficiary

Patient's spouse may authorize disclosure of patient's health information only when the health information is for the sole purpose of processing an application for health insurance, for enrollment in a health care service plan, or any employee benefit plan. Patient is to be an enrolled spouse or dependent under the policy or plan.

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NAME: _____ DATE: _____

ALLERGIES

MEDICATION NAME	TYPE OF ALLERGIC REACTION

PHARMACY

(where you most frequently fill prescriptions)

Pharmacy: _____ Pharmacy #:_____ Pharmacy Fax:_____

MEDICATIONS CURRENTLY BEING TAKEN

(include all dietary, weight loss, and vitamin supplements)

MEDICATION NAME	DOSE	REASON FOR TAKING

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NAME: _____ DATE: _____

Height: _____ Weight: _____

MEDICAL PROBLEM LIST

Please check/circle all current and significant past medical problems and explain below.

HEART
- ☐ heart disease
- ☐ stroke
- ☐ swelling of hands/feet
- ☐ high blood pressure
- ☐ high cholesterol
- ☐ pacemaker or implanted defibrillator
- ☐ irregular heartbeat

RESPIRATORY
- ☐ asthma
- ☐ exposure to tuberculosis
- ☐ other respiratory/lung disorder

ENDOCRINE
- ☐ thyroid eye disease
- ☐ diabetes
- ☐ Graves' disease
- ☐ Hashimoto's thyroiditis
- ☐ thyroid nodule(s)
- ☐ thyroid cancer
- ☐ other endocrine disorder _
- ☐ other thyroid disorder

PERIPHERAL VASCULAR
- ☐ DVT (deep venous thrombosis)
- ☐ other vascular disorder

GENERAL/CONSTITUTIONAL
- ☐ headache
- ☐ chronic fatigue

PSYCHIATRIC
- ☐ depression
- ☐ anxiety

HEMATOLOGY
- ☐ easy bruising or bleeding
- ☐ blood cancer
- ☐ other cancer

EAR, NOSE, THROAT
- ☐ sinus problems
- ☐ sleep apnea
- ☐ other head and neck concerns

SKIN
- ☐ skin cancers
- ☐ scarring tendency
- ☐ areas of lighter or darker skin
- ☐ changes in nails

MUSCULOSKELETAL
- ☐ back problems
- ☐ shoulder weakness or pain
- ☐ restless leg syndrome

ALLERGY / IMMUNE
- ☐ itching eyelids
- ☐ itching eyeballs
- ☐ rheumatoid arthritis
- ☐ lupus
- ☐ Sjogren's disease
- ☐ colitis
- ☐ HIV disease
- ☐ other autoimmune disease

NEUROLOGIC
- ☐ intermittent vision disturbance
- ☐ frequent blinking or eye/face spasms
- ☐ Bell's palsy

GASTROINTESTINAL
- ☐ hepatitis
- ☐ jaundice
- ☐ reflux
- ☐ bleeding ulcers

EYE / OPHTHALMOLOGIC
- ☐ vision change
- ☐ dry eyes
- ☐ tearing
- ☐ retinal problems
- ☐ glaucoma

OTHER

_____

SURGERY ROS

Allergic to Iodine ☐ Yes ☐ No Allergic to latex ☐ Yes ☐ No On blood thinners? ☐ Yes ☐ No

Have you used drugs other than those for medical reasons in the past 12 months? ☐ Yes ☐ No

Please Explain Your Significant **MEDICAL PROBLEMS, SURGERIES & HOSPITALIZATIONS:**

_____

_____

_____

Please check **DISEASES** that run in your **FAMILY:**

☐ Thyroid disorder	___ Father ___ Mother ___ Brother ___ Sister ___ Son ___ Daughter
☐ Droopy eyelid(s)	___ Father ___ Mother ___ Brother ___ Sister ___ Son ___ Daughter
☐ Thyroid disorder	___ Father ___ Mother ___ Brother ___ Sister ___ Son ___ Daughter
☐ Other _____	___ Father ___ Mother ___ Brother ___ Sister ___ Son ___ Daughter

Do You **Smoke**? Y / N Did you EVER? Y/ N How many packs /day? _____ How many years? _____

Do You Drink **Alcohol**? Y / N How many drinks / day? _____

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INFORMATION SHARING

NAME: _____ DATE:_____

HOW MAY WE CONTACT YOU?

HOME PHONE:_____ ☐ EMERGENCY ONLY ☐ ROUTINE ☐ OK TO LEAVE DETAILED MESSAGES

WORK PHONE:_____ ☐ EMERGENCY ONLY ☐ ROUTINE ☐ OK TO LEAVE DETAILED MESSAGES

CELL PHONE: _____ ☐ EMERGENCY ONLY ☐ ROUTINE ☐ OK TO LEAVE DETAILED MESSAGES

EMAIL:** _____ ☐ EMERGENCY ONLY ☐ ROUTINE ☐ OK TO LEAVE DETAILED MESSAGES

PREFERRED METHOD OF COMMUNICATION FOR APPPOINTMENT REMINDERS ** ☐ EMAIL ☐ TEXT ☐ PHONE CALL ☐ OPT OUT

*****The more available you are to us, the more quickly we can provide you with important scheduling changes, visit reminders, laboratory results, peri-operative instructions, answers to your questions, etc.***

REFERRAL

Who referred you to our practice?

NAME:_____ Contact Info : _____ Please don't contact them ☐

LEGAL GUARDIAN

If you have appointed a legal guardian for your health and financial issues, please tell us who that is.

Guardian's Name:_____

PHYSICIANS / HEALTH CARE PROVIDERS

We believe it is in your best interest for us to know all the health care providers involved in your care, so that we may communicate relevant information in a timely fashion. Please list below all of your regular physicians and health care providers (including complimentary health care providers such as chiropractor, naturopath, dietician, and acupuncturist) with whom you are willing for us to communicate.

PROVIDER'S NAME	SPECIALTY	TELEPHONE NUMBER

FRIENDS AND FAMILY

Your privacy is very important to us. We cannot share any information (including confirming appointment date and time) with anyone, including a spouse or care-giving child (unless they are your legal guardian) without your expressed permission. Please list below all persons with whom you will allow us to fully discuss your medical issues.

INDIVIDUAL'S NAME	RELATIONSHIP	TELEPHONE NUMBER

Signature of Patient (or legal guardian): _____

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PAYMENT POLICIES

Thank you for choosing our practice to help with your surgical needs. The following policy has been developed to be fair to everyone including you, other patients waiting for surgery, anesthesiology staff who takes time off from their regular full-time hospital-appointed positions, our office staff, and your surgeon.

DEPOSIT

For cosmetic procedures, a **$500 deposit** is required at the time of scheduling. If procedure is cancelled/rescheduled within 14 business days prior to your surgery date, or cancelled/rescheduled your surgery twice, this deposit becomes non-refundable.

_____ **Initial**

For insurance-covered procedures, a **$50 deposit** is required at the time of scheduling. If procedure is cancelled/rescheduled within 14 business days prior to your surgery date, or cancelled/rescheduled your surgery twice, the deposit is non-refundable.

_____ **Initial**

For Facial Fillers, (Restylane/Juvederm/RHA) injections, a **$100 deposit** is required at the time of scheduling. If the appointment is cancelled/rescheduled twice or no show, the deposit becomes non-refundable.

_____ **Initial**

RESCHEDULING

We understand events may arise which may make it impossible for you to keep your surgery appointment. Please communicate all cancellations directly to our Surgery Scheduler, or our Office Manager, **Ms. Betty Broussard**.

Please give us as much notice as you can. Depending upon whether we have enough notice to fill your spot and/or whether significant insurance-covered or hospital-based procedure leg-work needs to be duplicated, a repeat deposit may be required to reschedule your procedure.

_____ **Initial**

PAYMENT DUE

Full payment of your responsibility for surgery is required on the Friday before the week of your surgery. For insurance-covered procedures, we will provide you with our very best ***ESTIMATE*** based upon anticipated surgical procedures, the most current information from your insurance company on your out-of-pocket expenses met to date and fee schedules. If you are using an anesthesiologist in our office, then full payment for this service is required on the Friday before the week of your surgery as well.

If you decide you would like to pay by check, it will be due 2 weeks prior to the Friday before the week of your surgery.

_____ **Initial**

CREDIT CARD PAYMENTS

We are happy to accept credit card payment at no additional charge to you. However, if you must cancel or reschedule your surgery *and you require a refund processed on your credit card*, then we must pass along to you a nine percent **(9%) processing fee** to cover state franchise taxes and the intermediary charges.

_____ **Initial**

Signature of Patient (or legal representative) _____ Printed Name of Patient (and legal representative, if applicable) _____ Date

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PERMISSION FOR PHOTOGRAPHS

I hereby grant permission to Plastic Eye Surgery Associates, PLLC (referred hereafter as PESA) to take photographs of me and my medical or cosmetically relevant condition for any or all of the following uses:

1.) Facilitate telephone conversations with PESA physicians regarding my condition.
2.) Documentation of any changes in my situation.
3.) Documentation for insurance purposes of medically necessary concerns.

In addition, I understand that such **photographs**, or **portions** thereof so **cropped** as to aid in masking my identity, may be used for teaching, clinical research purposes in lectures, publication, video or internet-based format without any remuneration to me. By signing this form, I release the medical practice of PESA from any future claims as well as liability arising from the use of said photographs, understanding that to protect my privacy, un-masked, full-face photographs will NOT be used in publication, unless I provide additional written consent.

Any photographs taken by PESA remain the express property of PESA as part of my medical record. Although, like the remainder of my medical record, I have legal right to obtain copies of the same upon written request in keeping with usual state and federal laws and PESA policies.

_____

Signature of Patient (or legal representative)

_____

Printed Name of Patient (and legal representative, if applicable)

_____

Date

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IMPORTANT INFORMATION FOR PATIENTS TAKING BLOOD-THINNING MEDICATION

Blood-thinners ("anticoagulants"), such as aspirin, Coumadin, Plavix, and Lovenox are powerful medications prescribed to prevent life-threatening blood clots responsible for heart attacks, brain strokes, lung strokes, and deep vein thrombosis.

However, bleeding is a potential complication of any surgery, and people taking blood-thinners around the time of their procedure or who have poorly controlled high blood pressure are at increased risk for developing bleeding and associated complications, such as increased bruising, surgery failure, and even vision loss or blindness.

But, if you stop taking your blood-thinner(s) before surgery to lessen the chance of bleeding, you increase your risk for developing life-threatening blood clots.

Thus, if you are on blood-thinners and wish to have surgery, you must accept the increased risk of one or the other of these complications — blood clots or bleeding.

Your surgeon and your primary doctor/cardiologist can offer you advice about the relative risks and benefits of stopping or continuing your blood-thinners around the time of your surgery. If you have not already obtained such advice, you may wish to do so.

Importantly, there are many other prescription and non-prescription medications and supplements which also affect your clotting and bleeding. A partial list has been provided in your surgery packet.

Note: If you are taking blood-thinners, even if you decide to stop these for your surgery, you should NOT take the anti-bruising vitamins we offer.

In the event that I am taking blood thinners (such as aspirin, Plavix, Coumadin, such as Lovenox) around the time of any surgery, I understand that stopping these medicines before surgery may increase my risk of a having a heart attack, stroke or other life-threatening blood clots. I also understand that if I continue my blood-thinners through surgery, I have an increased risk of bleeding complications that could result, in rare cases, in vision loss or blindness.

_____

Signature of Patient (or legal representative)

_____

Printed Name of Patient (and legal representative, if applicable)

_____

Date

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PARTICIPATION IN RESEARCH STUDIES

I understand that Plastic Eye Surgery Associates, PLLC (referred hereafter as PESA) is an innovative and progressive medical practice with a long history of developing both aesthetic and functional medical care advancements for all people around the world. As PESA constantly strives to improve medical care, a number of research studies are often performed. These fall into the three categories listed below.

1. **Non-Identifying, General Data Collection**
   Data may be collected from chart reviews and used to understand treatment overall outcomes or patient characteristics. Specific identifying data is never published. *A simple example of this type of study might be one that examines how long a specific upper eyelid procedure lasts before men or women of different ages seek additional treatment.*

2. **Discarded Tissue Use**
   Tissues obtained during surgery that would normally be discarded (*such as upper eyelid skin removed during a blepharoplasty procedure*) might be used in laboratory studies. *A simple example of this type of study might be one that examines the amount of eyelid collagen to better understand the impacts of sun-damage and aging in the skin of men versus in those in women.*

3. **Disorder Modifying Therapy**
   When two different treatments are available, and it is not yet clear which is better, studies are sometimes performed where people are randomly assigned to one treatment or the other. If you are asked to participate in a study of this type, you will be given a separate, detailed consent form, explaining the nature of the study and the possible impact it might have on you. You will never be included in a study of this type without being given such information and obtaining your specific consent in advance of that study and treatment. *A simple example of this type of study might be one that examines whether using cold compresses for two days after surgery results in less bruising and faster healing than using cold compresses for just one day.*

Having read and understood the above, I hereby grant permission to PESA to use my treatment data and/or otherwise discarded tissue in studies of the type described above under study types 1 and 2 without any further notification. Such information and/or tissue may be used for teaching, research, or publication purposes without any remuneration to me. I hereby release PESA from any liability or claims resulting from the use of such data and/or tissue. I understand that I will never be entered into a "Disorder Modifying Therapy" study without my express permission prior to treatment.

I understand that all studies conducted by PESA attempt to adhere to the World Medical Association's Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects. Details of this regularly updated document are available on the world-wide web at www.wma.net.

_____

Signature of Patient (or legally responsible representative)

_____

Printed Name of Patient (and legally responsible representative, if applicable)

_____

Date

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RECONSTRUCTIVE, MEDICAL PROBLEMS WHICH MIGHT NOT BE COVERED BY YOUR HEALTH INSURANCE

I understand that even though I might have a medically important problem, certain health insurance companies and specific health insurance plans may deny coverage and payment for my office visits and corrective procedures under various conditions, including the following:

- **INJURIES OCCURING AT A RESIDENCY** – in which your health insurance company believes the homeowner's insurance should provide coverage.
- **INJURIES RELATED TO A MOTOR VEHICLE ACCIDENT** – in which your health insurance company believes the automobile insurance should provide coverage.
- **INJURIES OCCURING AT THE WORK PLACE OR RELATED TO WORK REQUIREMENTS** – in which your health insurance company believes that Workers Compensation should provide coverage.
- **INJURIES RESULTING FROM COSMETIC SURGERY** – an increasing number of health insurance companies are denying reconstructive procedures in this situation.
- **INJURIES RELATED TO SUBSTANCE (AB)USE** – some health insurance companies will deny coverage in certain circumstances for injuries related to excessive alcohol ingestion or the use of illicit pharmaceutical substances.
- **PRE-EXISTING EXCLUSION CLAUSE** – some health insurance companies will deny coverage for a period of time (usually one or more years) for medical problems which existed at the time of acquiring the insurance coverage. Such problems should be detailed in your personal health care contract and should also be available from your insurance carrier by phone.

I understand that I am personally responsible for a true, accurate, and complete disclosure of my medical history and that whatever information is communicated to Plastic Eye Surgery Associates, PLLC will become part of the medical record, fully available to my health insurance company for review upon their request or to any United States court upon subpoena.

I further understand that if for any reason (including, but not limited to the above) my insurance health care plan denies coverage for services by Plastic Eye Surgery Associates, PLLC, then I am solely responsible for incurred fees and any resolution of such issues with my health care insurance provider.

_____

Patient/Representative Signature

_____

Printed Name

_____

Date

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PLASTIC **EYE** SURGERY ASSOCIATES, PLLC

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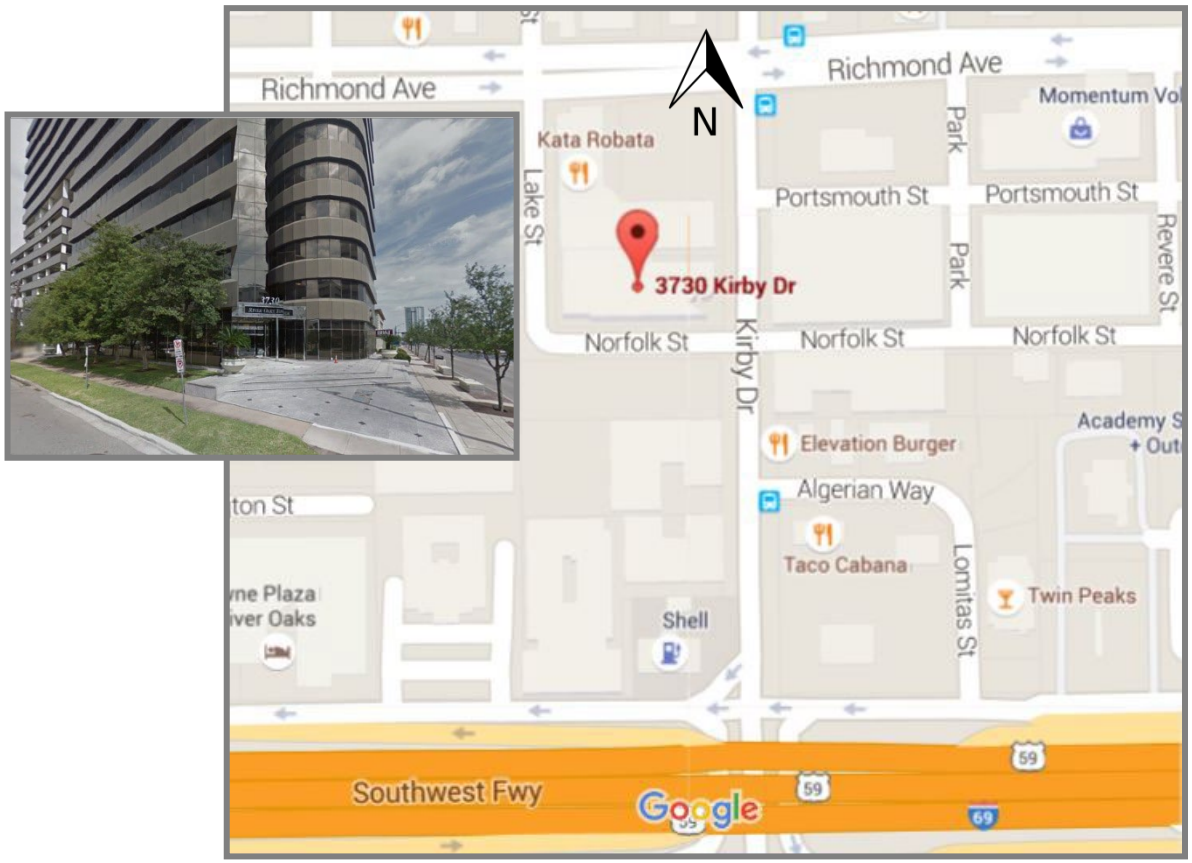
Houston, TX 77098

Tel. 713/795-0705

Fax 713/807-0630



The entrance to the Parking Garage is off Norfolk Street. You may park on any floor you wish. Enter the building and take the elevator to the 9th floor. Wheelchair ramps are available on the 1st and 3rd Floor.

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COVID-19 RISK AWARENESS

I understand that I am consenting to an elective office visit/treatment/procedure/surgery that is not urgent or emergent. I also understand that the coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization, and that COVID-19 is extremely contagious and is believed to spread by person-to-person contact. As a result, federal and state health agencies recommend social distancing.

I understand that my doctor at Plastic Eye Surgery Associates has put in place what are currently believed to be the most up-to-date, reasonable safety measures to help reduce the spread of COVID-19.

I understand that even if I have received a negative COVID-19 test result, the test may have failed to detect the virus, or I may have become infected after I took the test. I understand that even if I do not have any symptoms, I may have a COVID-19 infection, and that having the elective office visit/treatment/procedure/surgery can lead to a higher chance of complication and death.

I understand that exposure to COVID-19 before, during, and after my elective office visit/treatment/procedure/surgery could result in any of the following: a positive COVID-19 diagnosis, extended isolation, additional tests, and hospitalization (up to and including: the need for treatment in intensive care (ICU), short-term or long-term intubation, other complications, and death).

I understand that COVID-19 may cause additional risks, some of which may not be known at this time, and that after my elective office visit/treatment/procedure/surgery I may need additional care that may require that I go to an emergency department or hospital.

I understand that any elective treatment/procedure/surgery in itself may also require additional care, which may require that I go to an emergency department, other specialist, or hospital.

I understand that this elective office visit/treatment/procedure/surgery procedure may put me at increased risk for becoming infected with COVID-19. By signing this consent, I accept that risk and give my permission to proceed with an office visit/treatment/procedure/surgery. I have been given the choice to have my office visit/treatment/procedure/surgery at a later date. I understand the potential risks of delaying and want to proceed. I have read this consent, or someone has read it to me.

_____ _____ _____

Name of Patient Signature Date