COVID-19 RISK INFORMED CONSENT

I wish to be seen for a dermatologic issue(s). I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing. I recognize that the doctors and staff at Northern Bergen Dermatology are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is inherent risk of becoming infected with COVID-19 by virtue of being seen in Northern Bergen Dermatology's offices. I hereby acknowledge and assume this risk, and I give my express permission for Northern Bergen's doctors and staff to proceed with my upcoming visit(s).

I understand that, even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test. I understand that possible exposure to COVID-19 before/during/after my upcoming visit(s) may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death.

I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my upcoming visit(s).

WRITTEN ACKNOWLEDGEMENT

☐ **I hereby acknowledge receipt of Bergen Dermatology Specialists COVID-19 informed consent.**

Patient Name: .....

OR

I am a parent/legal guardian of Name: .....

☐ **I hereby acknowledge receipt of Bergen Dermatology Specialists COVID-19 informed consent.**

Name: ..... Relationship to patient: .....

☐ **I understand if I have any questions regarding this form I can call the office prior to signing.**

DATE **SIGNATURE** (Signature of Patient or Person Authorized to Sign for Patient)

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