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COVID-19 INFORMED CONSENT AGREEMENT POLICY

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I, _____, consent to an in-person consultation and/or to have my Provider and/or his/her staff (hereinafter collectively “my Provider”) perform medical procedures, whether regarded as necessary, elective or aesthetic, during the time of the COVID-19 pandemic and after. I understand in-person consultations and/or having my procedure performed at this time, despite my own efforts and those of my Provider 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 may result in a more severe case of COVID-19 than I might have had without the procedure.

I also understand in-person consultations and/or having my procedure performed at this time increases the risk of my transmission of COVID-19 to my Provider & the Practice Staff. 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 Provider's office, I accept that my Provider will implement infection-control procedures with which I must comply, before, during and after my consultation and/or procedure, for my own protection as well as that of my Provider. I understand my cooperation is mandatory, whether or not I personally feel such COVID-19 procedures and/or preventive measures are necessary.

I have informed my Provider 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 Provider. I understand my Provider 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 Provider before I may receive my procedure.

SIGNATURE _____

DATE ____/____/____