

## **In Office Visit During COVID Patient Authorization and Consent Form**

During the COVID-19 pandemic, there is some increased risk for patients who visit a healthcare provider. Health problems can happen from being exposed to:

- other patients,
- healthcare staff, or
- healthcare facilities.

Some patients have a higher risk of complications from COVID-19, including those with:

- asthma,
- chronic lung disease,
- serious heart disease or problems,
- chronic kidney disease,
- extreme obesity,
- a compromised or suppressed immune system,
- liver disease,
- pregnant,
- age 65 or older, or
- nursing home or long-term care facility residents.

If these high-risk patients get COVID-19, they may have a greater chance for having more health problems. These may be serious. Patients may need to be in the hospital. They could even die.

### **Other Evaluation and Treatment Choices**

There may be other ways to meet with your doctor and be treated. You could have:

- a phone evaluation or
- a telehealth evaluation.

These other options may or may not be right for you. This depends on your health problem and overall health. If remote assessment and treatment are not appropriate, your doctor will explain why you need an in-person visit.

### **More Facts**

Medical and office staff may help your doctor when you arrive and while you are evaluated and treated. They will follow state laws and recommendations from local, state, and national health officials related to caring for patients during the COVID-19 pandemic. However, they cannot eliminate risks, especially for high-risk patients.

**Consent to Treatment**

\_\_\_\_\_The first page of this consent form told you about COVID-related risks. If, after reviewing this form, you do not believe that you really understand the risks and choices, **do not sign the form until all questions have been answered.**

\_\_\_\_\_I understand the facts provided to me on the first page of this consent form. I give my consent for in-office evaluation and treatment. By signing below, I agree that staff/doctor has discussed the facts in this form with me, that no one has given me any guarantee, that I have had a chance to ask questions, and that all of my questions have been answered.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date and Time

\_\_\_\_\_  
Relationship to Patient (if Responsible Party is not Patient)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date and Time