Bella Via Skin and Body Therapies

beauty through health and wellness

COVID-19 RISK INFORMED RELEASE

I, _____, understand that I am opting for an elective treatment that is not urgent and may not be medically necessary.

I also understand that the novel Coronavirus (COVID-19) has been declared a worldwide pandemic by the World Health Organization. I further understand COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and health agencies recommend social distancing. I recognize that Drs. Colville and Zavell and the staff of Bella Via are closely monitoring this situation and have put in place reasonable preventive measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment, and I give my express permission for Drs. Colville and Zavell and all the staff at Bella Via to proceed with the same.

I understand that even if I have tested for COVID-19 and received a negative test result, the test in some cases may fail to detect the virus or I may have contracted COVID-19 after the test. I understand that, if I have COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before/during/after my treatment 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 of intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In additions, after my elective treatment, I may need additional care that may require me to go to an emergency room or a hospital.

I understand the COVID-19 may cause additional risks, come or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment itself.

I have been given the option to defer my treatment to a later date without penalty. However, 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 desired treatment.

____Patient Initials

I understand this explanation and have no more questions and consent to the treatment.

_____

Patient or Person Authorized to Sign for Patient Date/Time

Witness_____**Date/Time**_____

Affiliated with Reconstructive & Aesthetic Surgeons, Inc.
419.534.6551 • www.RASInet.com

Craig W. Colville, M.D., F.A.C.S.
John F. Zavell, M.D., F.A.C.S.