COVID-19 RISK INFORMED CONSENT

I 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 understand that The Naderi Center is taking extensive safety precautions to reduce the spread of COVID-19 and has developed specific policies and guidelines to safeguard patients and staff. These policies and procedures include, but are not limited to, the mandatory use of personal protective equipment (PPE) by doctors, staff, and patients, enhanced office sanitization practices, the use of air filtration and UV purification devices, the use of barrier shields where feasible, decreased patient volume, and zero tolerance for illness at the workplace. As a patient entering The Naderi Center, I am required to be in good health, wash my hands prior to entering exam rooms and use a face covering at all times. As a patient entering The Naderi Center, I understand my face covering may only be removed by my provider when receiving treatment.

Despite The Naderi Center's extensive safety precautions, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of entering The Naderi Center facilities for any reason, including but not limited to, consultation, treatments, procedures, and/or surgery. I hereby acknowledge and assume any and all risks of becoming infected with COVID-19 by entering The Naderi Center facilities in Virginia, Maryland, and/or any associated facilities such as laboratories, surgery centers, hospitals, etc. associated with my treatment and care. I am voluntarily proceeding at my own free will, and I hold harmless and indemnify The Naderi Center, its doctors, **Dr. Shervin Naderi**, **Dr. Jessica Kulak**, **Dr. Erica Anderson, and Dr. Alexandra Snodgrass,** and its staff against any legal action now or in the future.

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, if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective consultation, treatment, procedure, and/or surgery can lead to a higher chance of complication and death, and it places the clinical team and staff at risk.

I understand that possible exposure to COVID-19 before, during, and/or after my consultation, treatment, procedure, and/or surgery 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, loss of income from work, and other potential complications, and the risk of death. In addition, after my elective consultation, treatment, procedure, and/or surgery, I may need additional care that may require me to go to an emergency room or a hospital, and I understand all such associated costs are my sole responsibility. I understand that COVID-19 may cause additional risks, some 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/procedure/surgery itself.

I have been given the option to defer my consultation, treatment, procedure, and/or surgery to a later date. 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 consultation, treatment, procedure, and/or surgery.

I also consent that:

- **I have NOT been in close contact with a person who is ill or known to have COVID-19.**
- **I do NOT currently have a fever or any respiratory symptoms such as cough or shortness of breath.**

Patient (or legal guardian) Print Name   Patient (or legal guardian) Signature   Date