PREMIER HEALTH CONSULTANTS OF NORTHERN VIRGINIA
Premium Care. Personal touch.

PREMIER HEALTH CONSULTANTS OF NORTHERN VIRGINIA
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COVID-19 Pandemic Treatment Consent Form

Name: _____ DOB: ____/____/_____

Office: ☐ Reston ☐ Dulles Provider: Dr. Namjoshi

You have elected to receive care during the events of the COVID-19 National Emergency. We are providing this special consent, in addition to any procedure-specific consent that you may receive, because of the unique circumstances of the current COVID-19 pandemic. Some considerations to keep in mind as you seek medical treatment under these unique circumstances:

- Traditionally office visits have a relatively small risk of infection. However, the COVID 19 pandemic and the ongoing community transmission of the COVID-19 virus creates additional risks from being in the proximity of Healthcare providers, patients, or staff.
- Social distancing of 6 feet or more is not always possible during in person office visits, which may increase the chances of COVID-19 transmission.
- We are following infection control protocols diligently, which may limit the spread of the disease, but there is a still a possibility of transmission to you (and to others you come into contact with after leaving this office) of the COVID-19 virus which can cause serious health problems, including but not limited to, severe respiratory problems, high fevers and death.
- Here is what we are doing to protect you the patient, team members and ourselves:
    - We are following safety directives from the state and CDC as a way to limit patient and staff exposure to this virus.
    - We engage in a daily office preparation safety routine.
    - We conduct patient and staff COVID-19 screening.
    - We utilize personal protective equipment for office staff and patients and provide training to our staff on the proper methods of putting on and removing this equipment.
    - We implement cleaning and disinfecting protocols before the office opens and between patients.
    - All team members follow applicable guidelines for sterilization and surface disinfection procedures.
    - We implement protocols to minimize crowding in the office including online/over the phone check in, expedited exam room assignments etc.

My Initials by each statement indicate my understanding and acceptance:

Initial

☐ I understand that the COVID-19 Virus has a long incubation period during which carriers of the virus may not show symptoms but may still be highly contagious. It is impossible to determine who has it and who does not, given the current limits in the virus testing.

☐ I understand that there is still much we do not know about the COVID-19 Virus and, therefore, there may be risks that are yet unknown.

☐ I confirm that I am NOT presenting with any of the following symptoms of COVID-19 listed below:

- Fever > 100.4
- Shortness of breath or difficulty breathing
- Dry Cough
- Chills
- Reseated shaking with chills
- Muscle pain
- Headache
- Sore throat
- New loss of taste and/or smell

☐ I understand that travel by air, bus or train significantly increases my risk of contracting and transmitting the COVID-19 virus, and I verify that I have not traveled domestically within the United States by commercial airline, bus, or train within the past 14 days.

☐ I verify that I have not traveled outside of the United States in the past 14 days to countries that have been affected by the COVID-19 virus.

☐ I understand that the CDC currently recommends social distancing of at least 6 feet or more under many circumstances and that social distancing of 6 feet or more is not always possible during office visits.

The safety and well-being of our patients continues to be our primary concern. We will continue to monitor the status of COVID-19 nationally and within our community and update office policy as needed to continue to provide services to our community.

Initial

☐ I confirm that I have read this entire document, and I knowingly and willingly consent to have medical treatment during the COVID-19 pandemic.

Signature of patient/surrogate: _____

Name of patient/surrogate: _____

Date: _____