TODD B. KOCH, MD
6315 SHERIDAN DRIVE
WILLIAMSVILLE, NY 14221
716-631-1220

COVID-19 RISK INFORMED CONSENT

I _____ (patient name) understand that I am opting for an elective consultation/ treatment/procedure/surgery 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 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 recognize that Dr. Todd Koch and all the staff at Amherst Cosmetic and Plastic Surgery Center are closely monitoring this situation and have put in place reasonable preventative 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 consultation/ treatment/procedure/surgery. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective consultation treatment/procedure/surgery, and I give my express permission for Dr. Todd Koch and all the staff at Amherst Cosmetic and Plastic Surgery Center to proceed with the same.

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/surgery can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before/during/after my consultation/treatment/procedure/ 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, other potential complications, and the risk of death. In addition, after my elective consultation/ treatment/procedure/surgery, I may need additional care that may require me to go to an emergency room or a hospital.

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 consultation/treatment/procedure/surgery itself. I have been given the option to defer my consultation/treatment/procedure/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/surgery.

I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE TERMS

Patient Signature_____Date/Time_____

Witness_____Date/Time_____

I have been offered a copy of this consent form (patient's initials)_____

AMHERST COSMETIC SURGERY CENTER **TODD B. KOCH, MD, FACS**

Patient Name: _____ Mobile Phone #: _____

E-Mail Address: _____ Social Security #: _____

Street: _____ City: _____ State: ____ Zip: _____

Date of Birth: _____ Age: _____ Sex: _____

Name of Employer: _____ Occupation: _____

Marital Status: _____ Spouse/Partner's Name: _____

Primary Care Physician: _____ Phone #: _____

Whom may we thank for the referral? _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Medical Insurance: _____ ID #: _____

Subscriber's Name: _____ Group #: _____

PLEASE PRESENT YOUR DRIVER'S LICENSE AND INSURANCE CARD UPON ARRIVAL.

Please list any medical problems:

Blood Pressure:	Heart:
Bleeding Disorders:	Diabetes:
Hepatitis:	Lungs:
HIV:	Kidneys:
COVID-19:	Cancer:

Other illnesses: _____

_____

_____

Previous surgeries: _____

_____

Medications/Supplements: _____

_____

Allergies to Medications: _____

Smoker: _____ How much? _____ Average alcohol consumption? _____

REASON FOR APPOINTMENT: _____

_____

QUESTIONS TO ASK PATIENT OVER THE PHONE

1. Do you or anyone in your household have any symptoms of COVID 19 in the last 14 days.....fever, cough, shortness of breath, difficulty breathing, chills, muscle pain, headache, sore throat, new loss of taste or smell etc.?
2. Any recent travel out of the area?
3. Do you live with anyone who is in contact with COVID patients?
4. Have you had COVID 19?
5. Have you been in contact with anyone who contracted COVID 19? Nurse? Emergency Responder?
6. Have you or anyone in your household been tested for COVID 19? Antibody test?
7. Have you or any member of your family been told to self-quarantine?
8. Have you or anyone in your household visited a hospital or nursing home in the last 30 days?
9. Have you been social distancing?