Innovative Aesthetics
MEDICAL SPA AND LASER CENTER

COVID 19 Treatment Consent & Post Care instructions

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 that COVID-19 is extremely contagious and is believed to spread by person-to-person contact and accordingly, federal and state health agencies recommend social distancing. I recognize that the medical providers and staff at Innovative Aesthetics Medical Spa are closely monitoring this situation and have put in place reasonable preventive measures targeted to reduce the spread of COVID-19. Given the nature of the virus, however, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment. Accordingly, I acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure, and I give my express permission for the medical providers and staff at Innovative Aesthetics Medical Spa 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, proceeding with this elective treatment/procedure can lead to a higher chance of complication (such as infection to the treated area). I understand that possible exposure to COVID-19 before/during/after my treatment/procedure may result in any of 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 treatment/procedure, 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 in this Informed Consent, as well as those risks for the treatment/procedure itself. I have been given the option to defer my treatment/procedure 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 treatment/procedure. I acknowledge that I have been offered a copy of this consent form. I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE PROCEDURE.

Patient Initials_____

Pre Treatment - COVID 19

- I have not:
    - Traveled in the last 14 days
    - Been exposed to anyone that has been tested positive for Covid19 in 20-30 days
    - Had any fever in the past 2 weeks
    - Had a cold or flu-like symptoms in the past 2 weeks
    - Had unusual coughing or sneezing in the past 2 weeks
    - Had a decrease in you sense of smell or taste
    - Have you had the Covid19 virus test?

      When? _____ Where? _____ Result _____

Post Treatment - COVID 19

- There is a risk of fillers moving due to pressure from protective facial masks or shields worn outside of clinic.
- There is an increased infection risk and other complications (acne, rash, etc.) from wearing protective face masks through exposing open wounds and treated skin to bacteria.

  Subsequently, clients will be sent home with a clean surgical mask after treatment/procedure. Masks should be removed immediately once in private vehicle and remain off for 48 hours.

Client Name: _____

Client Signature: _____ Date: _____