

COVID-19 Pre Screen Questionnaire

1. Have you traveled within the last 4 weeks internationally or out of state? YES or NO

-If yes, to which area(s)? _____

2. Have you had contact with anyone suspected to have COVID-19 or that has symptoms of COVID-19 in the last few weeks? YES or NO

3. Have you had any of the following symptoms in the last 2 weeks? (If yes, Please Circle)

- | | |
|--|--------------|
| -fever in the last 2 weeks? (99 degrees or higher) | -Cough |
| -Repeated shaking with Chills | -Chills |
| -Shortness of Breath/difficulty breathing | -Muscle Pain |
| -Loss of taste or smell | -Headache |
| -Sore Throat | -Diarrhea |

-Known close contact with a person who is lab confirmed to have COVID-19

4. Have you had any other upper respiratory system complications or symptoms in the last few weeks?

YES or NO, if yes, please explain: _____

5. Have you tested positive for COVID-19? YES or NO

-If yes, are you completely recovered and completed the 14 day quarantine? YES or NO

-(If Yes, Please bring a copy of your Doctor's release/recovery documentation for you chart.)

6. Do you have immunosuppression? YES or NO

7. Are you pregnant? YES or NO

8. Are you breastfeeding? YES or NO

9. Have you watched the "Proper Handwashing" video on our website as required? YES or NO

- I have answered all questions honestly and to the best of my ability.

Name: _____ Date: _____

I understand that I am choosing to come in for elective procedures. By coming in for treatment(s), I understand that I am doing so at my own risk and will not hold Asa Skin Rejuvenation Clinic, any of its employees or affiliates liable for contraction of any illnesses. I understand that Asa Skin is maintaining guidelines from the CDC and Federal Government for the health benefits of myself and others. I understand that upon arrival for my appointment, I may be asked to reschedule if there are any health concerns.

Signature: _____ Date: _____

Witness Signature: _____



COVID-19 RISK INFORMED CONSENT

I _____ (patient name) understand that I am opting for an elective 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. Joseph Perlman and all the staff at Asa Skin Rejuvenation Clinic and Bambi Scruggs 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 treatment/procedure/surgery. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure/surgery, and I give my express permission for Dr. Joseph Perlman and all the staff at Asa Skin Rejuvenation Clinic and Bambi Scruggs 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 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 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 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 treatment/procedure/surgery itself.

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

INFORMED CONSENT FOR COVID-19 RISK

I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE PROCEDURE.

Patient Signature: _____ Date/Time _____

Patient or Person Authorized to Sign for Patient Date/Time

Witness: _____ Date/Time _____

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



COVID-19 Pre Screen Protocol/Guidelines

We are glad to be back in the office and serving you! During this time, we are following CDC and Federal Government guidelines to start operations again. Please note our updated guidelines for when coming to your appointment. We appreciate your understanding and compliance of these new protocols.

1. Please bring your COVID-19 Questionnaire and Protocol/Guideline sheets with you to your appointment already filled out and signed. This will help us stay on time for everyone's appointments.
2. Please be courteous and arrive to your appointment wearing a mask.
3. We have uploaded a video to our website showing how to properly wash hands. Please watch this before arriving to your appointment.
4. With 6 feet social distancing and minimizing group settings still in effect, please give us a call when you arrive for your appointment. Once the previous patient leaves, we will call you to let you know that you may come up to the office. We will not be letting anyone use the waiting area during this time. Also, please come to your appointment alone. Any additional persons will be asked to wait outside or in their car. We ask you to please make arrangements for someone to look after any children while you come to your appointment. Thank you for understanding.
5. When you come up to the office, Holly Anne or another Asa Skin Employee, will take your signed forms, make sure that you are wearing your mask, and check your temperature. Anyone with an elevated temperature of 99 degrees or higher may be asked to reschedule.
6. Once the forms are taken and temperature checks out, you will then be asked to wash your hands in our restroom before you are taken into the treatment room.

I have read the this entire form and understand what to expect when arriving for my appointment(s) at Asa Skin until further notice.

Signature: _____ Date: _____

Witness: _____