ELITE WELLNESS & BEAUTY, INC.
COVID-19 RISK INFORMED CONSENT

I _____ (client name) understand that I am opting for an elective treatment/procedure/service 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 Elite Wellness & Beauty, INC. is 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/service. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure/service, and I give my express permission for Elite Wellness and Beauty employees and independent contractors 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/service can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before/during/after my treatment/procedure/service 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, and 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/service, 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/service itself.

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

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

_____

_____ _____
Client or Person Authorized to Sign for Patient Date/Time

Witness _____ Date/Time_____

I have been offered a copy of this consent form (p

Elite Wellness & Beauty COVID-19 Assessment.

NAME_____ DOB_____

CONTACT NUMBER_____

Have you been to one of the COVID-19 affected countries in the last 30 days?
YES_____ NO_____

Have you been in close contact with a confirmed case of Coronavirus?
YES_____ NO_____

Are you currently experiencing symptoms (cough, shortness of breath, fever)?
YES_____ NO_____

***By signing this form I hereby confirm that the information I have given above is true.**

Signature_____ Date_____

For office use:

Date_____ Temperature:_____ Initials:_____

Date_____ Temperature:_____ Initials:_____

Date_____ Temperature:_____ Initials:_____

Date_____ Temperature:_____ Initials:_____

atient’s initials) _____