COVID-19 Emergency Treatment - Patient Consent Form

HR for Health Disclaimer

The patient consent form below is a sample document that you may customize and provide to patients if they need to receive emergency treatment during the COVID-19 outbreak.

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As such, this waiver is simply to make patients aware of their risk receiving treatment in your Practice and may not protect you from any liability that may occur as a result of your decision to treat the patient. Practices should follow all federal, state and local regulations including, but not limited to, the CDC and OSHA to protect employees and patients during this time.

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Please note that all policies and forms that we provide should be reviewed by your legal counsel to ensure full compliance with your local, state and federal regulations and that is in accordance with your specific business needs.

Document Format

This form is in PDF format. If you do not have a PDF editor, please copy and paste into another document editor to customize to your Practice.

COVID-19 Emergency Treatment Consent Form

I, _____ (the patient), consent to receive emergency treatment from [Practice Name] during the COVID-19 outbreak.

I understand there is much to learn about the newly emerged COVID-19 including how it spreads and transmitted.

I understand that based on what is currently known about COVID-19 the spread is thought to occur mostly from person-to-person via respiratory droplets among close contacts. I understand that close contact can occur from being within approximately 6 feet of someone with COVID-19 for a prolonged period of time or by having direct contact with infectious secretions from someone with COVID-19.

I understand that carriers of COVID-19 may not show symptoms but may still be highly contagious.

I understand that due to the unknowns of this virus, the number of other patients that have been in the practice and the nature of the procedures performed here, that I have an increased risk of contracting the virus by being in the practice and by receiving treatment in the practice.

I understand that under the CDC [and ADA if you are in Dentistry] guidelines, do not recommend proceeding with any treatment that is non-essential at this time.

I understand that the treatment I am receiving is an emergency because of the underlying infection, pain, or conditions that limit my normal day-to-day activities. I confirm I am seeking treatment for a condition that meets these criteria. _____(Initial)

[Include if you are in the Dental Industry] I understand that dental procedures have the potential to include aerosol-generating procedures as well as anticipated splashes and sprays, which are some of the ways that COVID-19 can be spread.

I understand that the symptoms listed below are representative of COVID-19:

- Fever
- Dry Cough
- Shortness of Breath
- Temperature
- Persistent pain or pressure in the chest
- Bluish lips or face

I confirm that I do not display or currently have any of the symptoms that are representative of COVID-19, which are outlined above: _____(Initial)

I understand that all travelers arriving from a country or region with widespread ongoing transmission, as outlined by the CDC, should stay home for 14 days to practice social distancing and monitor their health after their arrival.

I confirm that I have not traveled to any of the countries or regions with widespread ongoing transmission (Level 3 Travel Health Notice) in the past 14 days. _____(Initial)

I confirm, to the best of my knowledge, that I have not had close contact with an individual diagnosed with COVID-19 in the past 14 days. _____(Initial)

Patient Name:_____

Patient/Guardian Signature:_____

Date:_____

For Practice Use:

Doctor Signature:_____

Date:_____