Lefkoff PERIODONTICS
Maureen H. Lefkoff, DDS, MS, PA

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COVID-19 Informed Consent for Treatment

I understand that the novel coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Please initial in all places provided):

- I understand that Maureen H. Lefkoff, DDS, MS, PA has taken precautions to lessen the risk of spread of COVID-19 in her office, but cannot promise that patients are without risk. _____
- I understand that COVID-19 is known to be highly contagious. As a result, this office cannot ensure that patients will not come into contact with COVID-19 while at this office or while traveling to and from this office, despite any precautions that this office may take. _____
- I understand that exposure to COVID-19 is known to be dangerous and potentially fatal. The virus carries inherent risks associated both with infection and treatment, as well as the potential for lasting conditions. _____
- I understand that the risk of coming into contact with COVID-19 carries with it the risk of infecting others. It is important to understand that any contact with other people carries with it some risk of the subsequent spread of COVID-19, directly or indirectly, to people outside of this office. _____
- I understand that the COVID-19 pandemic is a new situation for all of us. I understand that there likely are risks associated with COVID-19 that are not fully understood or documented and by choosing to seek treatment during this pandemic I may be exposed to risks of an unspecified nature. _____
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:

Fever.	Shortness of breath.	Dry cough.	Nausea or vomiting.
Runny nose.	Sore throat.	Loss of taste or smell.	Diarrhea.

  _____
- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that in the past 14 days I have not traveled outside of the immediate area (Maryland, Virginia, or Washington, DC); or traveled by commercial airline, bus, or train. _____
- I hereby acknowledge and assume the risk of becoming infected with COVID-19 with dental treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____
- I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

Patient Signature:	_____	Parent/ Guardian Signature:	_____	Witness Signature:	_____
Name:	_____	Name:	_____	Name:	_____
Date:	_____	Date:	_____	Date:	_____

Snowden Professional Center
8600 Snowden River Parkway, Suite 204
Columbia, Maryland 21045

Telephone: (410) 992-6600
Facsimile: (410) 992-1616
www.LefkoffPeriodontics.com