NORTHERN VIRGINIA SURGICAL SPECIALISTS, LTD.

432 Hospital Drive	15195 Heathcote Blvd., #240	9001 Digges Road, #208
Warrenton, VA 20186	Haymarket, VA 20169	Manassas, VA 20110
(540)347-2805	(571)261-2782	(571)261-2782

COVID-19 PATIENT CONSENT FORM

Thank you for your continued trust in our practice. As with the transmission of any infectious disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus", at any time or in any place. Be assured that we follow state and federal regulations and use universal personal protection and disinfection protocols to limit the transmission of all diseases in our offices. Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. We have taken measures to provide protection and social distancing in our practice. Due to the nature of certain procedures, we provide, it is not always possible to maintain social distancing between our healthcare providers, staff, patients, and sometimes other patients at all times.

Although exposure is unlikely, do you accept these risks and consent to treatment? YES_____ NO_____

Patient's Full Name: _____

Patient's Signature:_____Date: _____

Parent/Guardians Full Name:_____

Parent/Guardians Signature: _____Date:_____

COVID HISTORY FORM

People with COVID-19 have had a wide range of symptoms reported - ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. People with these symptoms may have COVID-19. Have you, your child, others accompanying you to today's appointment, or anyone you have recently been in contact with experienced any of the following symptoms? Circle all that apply:

Fever of Chills	Cough	Fatigue
Headache	Diarrhea	Shortness of Breath
Difficulty Breathing	Sore Throat	Muscle or Body Aches
New loss of taste or smell		Congestion or Runny Nose
Nausea or Vomiting		

Have you, your child, others accompanying you to today's appointment recently been in contact with someone who has tested positive for COVID-19 or any other contagious disease? YES _____ NO_____
If yes, provide approximate dates of illness: ___/___/_____
I understand that if the answer to any of these questions is yes, I may be asked to reschedule today's appointment to a later date.

Patient's Full Name_____
Patient's Signature:_____Date:_____
Parent/Guardian Full Name:_____
Parent/Guardian's Signature:_____Date:_____