Associates in Plastic & Aesthetic Surgery

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Name_____ Date _____

Date of Birth _____ Age _____ Social Security No _____

Demographics ☐Male ☐Female ☐Single ☐Married ☐Divorced ☐Widowed

Reason for your Visit _____

Who referred you to this office ☐Doctor ☐Patient ☐Web Site ☐Other

Please elaborate (name and phone) _____

If your visit pertains to an injury, what was the date _____

Preferred Language ☐English ☐Spanish ☐Other _____

Ethnicity ☐Hispanic/Latino ☐Not Hispanic/Latino

Race ☐American Indian/Alaskan ☐Asian ☐African American ☐Native Hawaiian/Pacific ☐Other ☐White

---

PERSONAL INFO

Email _____ Cell #_____ Home #_____

Street _____ City _____ State _____Zip_____

WORK INFO

Occupation _____ Employer_____ Phone # _____

Street _____ City _____ State _____ Zip_____

INSURANCE INFO

Insurance Co. (primary) _____ (secondary) _____

Guarantor (Name of Primary Insured)

_____

DOB _____ SS# _____ Relationship to the patient _____

Who is your primary medical doctor (name and phone no.) _____

Charles A. Loguda MD Howard N. Tepper MD Jerrold Zeitels MD Richard Tepper MD

955 S. Springfield Ave Suite 105 Springfield, NJ 07081 908.654.6540

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Name_____ Age_____ Today's Date _____

Height _____ Weight _____ Please approximate your blood pressure (i.e. 120/80) _____

Any RECENT fever, chills or unintended weight loss? ☐Yes ☐No

Problems with your Heart (previous heart attack)? ☐Yes ☐No

Problems with your Breathing (asthma, shortness of breath)? ☐Yes ☐No

Do you have Obstructive Sleep Apnea? ☐Yes ☐No Do you use a CPAP machine? ☐Yes ☐No

Have you ever had a Blood Clot (DVT) in your legs? ☐Yes ☐No

Have you ever had excessive bleeding from surgery? ☐Yes ☐No

Have you ever had a complication from surgery? ☐Yes ☐No

*Please explain*_____

Have you ever had a complication from anesthesia (not including nausea / vomiting)? ☐Yes ☐No

Have you ever received a blood transfusion? ☐Yes ☐No

Did you have any metal implant? (where _____) ☐Yes ☐No

Do you smoke? ☐Never ☐Quit ☐Few cigs/day ☐½ pack ☐1 pack ☐> 1 pack/day

Do you drink Alcohol / Beer / Wine? ☐No ☐Yes (*if yes, please select* ☐social ☐few/week ☐heavy)

Current Medications ☐No ☐Yes (if yes, list name and dosage)_____

_____

Allergies to Medicine (or latex)? ☐No ☐Yes (what happens?) _____

_____

Do you take Blood Thinners? ☐No ☐Baby Aspirin ☐Full Aspirin ☐Coumadin ☐Eliquis

☐Pradaxa ☐Savaysa ☐Xarelto ☐Lovenox ☐Plavix

Do you take supplements? ☐No ☐Dong Quai ☐Ginger ☐Ginkgo Biloba ☐Vitamin E ☐Garlic

☐Ginseng ☐Omega-3 fatty acid ☐Feverfew ☐Other (names / dosages) _____

_____

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Current Medical Conditions (check all that apply)

☐***NONE***	☐COPD (emphysema)	☐Kidney Failure - Dialysis
☐Anxiety	☐COVID-19	☐Migraines
☐Asthma	☐Diabetes	☐Mitral Valve Prolapse
☐A-fib (atrial fibrillation)	☐Glaucoma	☐MRSA (Staph infection)
☐Bleeding Problems	☐Heart Attack ("MI")	☐Rheumatoid Arthritis
☐Cancer (explain below)	☐Heart (coronary) Disease	☐Seizures
☐CHF (heart failure)	☐Hepatitis or HIV	☐Stroke (or TIA)
☐Cholesterol (high)	☐High Blood Pressure	☐Thyroid (low)

Other Medical

_____

_____

Previous Surgery ☐No ☐Yes (please explain)

_____

_____

Family History ☐No ☐Yes (please explain)

☐Cancer ☐Heart Disease ☐Bleeding Problems ☐Other _____

_____

Have you *recently* experienced any of the following (you may underline or circle)?

☐Constitutional: Recent fevers or unexplained weight loss
☐Head-Neck: Recent vision changes, dry eyes or irritation, nasal problems, or neck pain
☐Heart: Recent chest pain, palpitations, a need to take nitroglycerin under your tongue, or angina
☐Lungs: Recent shortness of breath, cough, or difficulty breathing
☐Hematology: Easy bruising, difficulty clotting, very heavy periods, or frequent and/or excessive nose bleeds
☐GI: Recent stomach pains / nausea / vomiting / GI problems
☐Skin: Unexplained rashes, difficulty healing, wounds that won't heal, or skin cancer concern
☐Neuro: Recent headaches, dizziness, or poor balance
☐Hand: Change in fingertip feeling, weakness, dropping things unexpectedly
☐Musculoskeletal: Neuropathy, pain in calves when walking

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WELCOME TO THE PRACTICE

FROM OUR PHYSICIANS: Thank you for entrusting your care to us. We are all board-certified plastic surgeons who are licensed to practice medicine in the State of New Jersey. We are committed to providing safe, private and personalized care. Please note that when we are requesting your permission or consent, the forms used in this practice will make reference to your (or my) "provider(s)". "Provider(s)" refers to Dr. Charles Loguda, Dr. Howard Tepper, Dr. Jerrold Zeitels, and / or Dr. Richard Tepper.

PRIVACY PRACTICES / MY RIGHTS ACKNOWLEDGEMENT: I have received the Notice of Privacy Practices / My Rights and have been provided an opportunity to review it. The practice may use your email as a means of contacting you regarding business operations or in response to something you may have requested. We may send you general announcements regarding the practice, such as weather related closures, public health advisories, holiday wishes, information about new services or products offered, and other related material that may be of interest to you. We will not use your email for HIPAA-protected information until we have your consent. Your email and related information is not shared with third-party companies for advertising purposes. You may choose to opt-out from within the email.

WHAT IS EXPECTED OF YOU (the patient): It is our goal to provide you with the highest quality of care, and to treat you with respect and dignity. In order to do so, it is imperative that we have your fullest attention and cooperation. By initialing below, you are acknowledge that you understand the following; even with the best medical training and experience, a medical professional is not always capable of solving my medical problems. Therefore, I understand it is important that any and all recommendations made by "my provider" are followed completely in order to increase the likelihood of a positive and healthy treatment outcome. I acknowledge and understand that if "my doctor" prescribes medicine to me, that the proper taking of such medicine shall be my sole responsibility (or my guardian) and I agree to properly follow the prescribed dosage and instructions. I also understand that if "my doctor" recommends that I see another doctor, or receive another test (examples include a blood test, x-ray, CT scan, but this list is not inclusive), I will do so in a timely fashion because the recommendation is designed to help me achieve the best possible treatment outcome. I understand that it is not possible for any person in this office to constantly follow-up to ensure that I have followed these recommendations. Therefore, I understand that if I fail to see a specialist or obtain the test for which I was referred, this can risk my current health or increase future health risks.
I understand that it is solely my responsibility to follow any of the medial advice given by any medical person in this office and any bad outcome from my failure to follow the advice of my doctors should be expected. In addition, you agree to follow all of our instructions and be compliant with all aspects of your care, both pre-operative (pre-treatment) and post-operative (post-treatment). You acknowledge that failing to do so may result in an increased risk of complications and/or a sub-optimal result. You also understand that even with the best medical training and experience, a medical professional is not always capable of solving my medical problems. Therefore, I understand it is important that any and all recommendations made by Dr. Charles Loguda, Dr. Howard Tepper, Dr. Jerrold Zeitels, Dr. Richard Tepper and /or any of our other medically trained associates (also known as "my doctor"), are followed completely in order to increase the likelihood of a positive and healthy treatment outcome. I acknowledge and understand that if "my doctor" prescribes medicine to me, that the proper taking of such medicine shall be my sole responsibility (or my guardian) and I agree to properly follow the prescribed dosage and instructions. I also understand that if "my doctor" recommends that I see another doctor, or receive another test (examples include a blood test, x-ray, CT scan, but this list is not inclusive), I will do so in a timely fashion because the recommendation is designed to help me achieve the best possible treatment outcome. I understand that it is not possible for any person in this office to constantly follow-up to ensure that I have followed these recommendations. Therefore, I understand that if I fail to see a specialist or obtain the test for which I was referred, this can risk my current health or increase future health risks.
I understand that it is solely my responsibility to follow any of the medial advice given by any medical person in this office and any bad outcome from my failure to follow the advice of my doctors should be expected.

I have read the above paragraphs……**Patient Initials** _____**Date:** _____

(May 2020)

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PLAY A PART IN YOUR CARE: We encourage all patients to be involved in their care, so feel free to ask questions of anyone in this organization. Please speak the office manager about any concerns you may have (Diane Ballistreri). If you feel that concerns have not been addressed to your satisfaction, you may contact AAAASF at 888-545-5222 or by email at ***info@aaaasf.org***. You may also contact the office of the Medicare beneficiary Ombudsman James McCracken at 877.582.6995 or 609.943.4026, or at **http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html**

INFECTION CONTROL: Staff members are educated about proper infection control techniques upon hire and annually thereafter. They follow CDC guidelines. WE HAVE UPDATED OUR POLICIES WITH REGARD TO COVID-19. See our COVID consent form below.

PHOTOS, VIDEO OR DIGITAL IMAGES: Your signature confirms that you understand that photos, videos or digital images (collectively referred to as "images") may be obtained during treatment and that any or all may be used to document care. By signing, you consent to such "images" being taken and understand that our practice retains all ownership rights to these "images". You will be allowed to view them or obtain copies if you request. These "images" will be secured in a manner consistent with our privacy policy and maintenance of medical records. Any "images" of you may reveal private or personal details and may further reveal your identity, and your signature acknowledges your approval of this. See "authorization to release information" regarding release of such "images" and electronic / print / advertising uses.

HOW WE MAY USE YOUR INFORMATION

Our practice collects information and stores this information in a certified EHR system. Annual reporting requirements by state or federal agencies may require release of this information. When your permission is required, you will be asked to sign the necessary release forms. Generally speaking, we are permitted to release your information when it pertains to your treatment, payment, and healthcare operations. We do not sell your personal information. But we do collect your email and may use it from time to time for the purpose of notifying you about general practice information or new procedures, cosmetic services, and specials. You may choose to unsubscribe if you prefer not to receive such emails. Your email will not be used to transmit personal information or HIPAA-protected information unless you specifically give us permission for such use. You may email us at your discretion. However, our office emails are NOT encrypted. Thus anything you send to us, and any reply to such, will not be encrypted. Use caution when sending sensitive information. Furthermore, do not rely on email to transmit any medical information of an urgent or emergency nature. If you have a medical emergency, you should dial 911 or go to the nearest emergency room. If your concern is less than urgent, you may reach us at 908.654.6540.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize "my provider" or any "affiliate" to release any and all information regarding my treatment, including digital photos or "images", even if they reveal my identity or other private area on my body, to my insurance carrier(s), Workers' Compensation Carrier, Case manager, PIP representative or other health professional as necessary to obtain insurance pre-approval or payment, and to process my insurance claim(s) generated in the course of examination and /or treatment. "Affiliate" refers to any outside company we hire to assist with our business operations. A photocopy of my signature and agreement is to be considered as valid as the original. This order will remain in effect until revoked by me in writing.

I have read the above paragraphs……**Patient Initials** _____**Date:** _____

(May 2020)

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FINANCIAL POLICY regarding INSURANCE BENEFITS: If your "provider(s)" participates with your insurance plan, he will submit claims for services rendered, but co-payments and deductibles are due at the time of your visit unless other arrangements have been made. If you require special arrangements regarding payment, please raise this concern prior to services being rendered. If a referral is required, it is your responsibility to obtain one. Otherwise, without such, you will be responsible for the full payment.

Please be advised that a list of the insurance plans with which each of our physicians participates is located on our website, www.NJPlasticSurgeryGroup.com. This information is also available from our office upon request. If your health plan is not listed on our website or communicated to you at the time of your appointment as a benefit plan with which your physician participates, such means that the doctor does not participate in that network of your healthcare plan. Out-of-network physicians are not contractually bound by your healthcare plan rates and are permitted to charge more. The estimated amount that will be billed to you is available upon request and our practice will do its best to convey your financial responsibility prior to any services being rendered. Unforeseen medical circumstances may arise when services are provided, and such may result in a higher fee.

Depending on your specific plan, you may have financial responsibility for services related to your out-of-network deductible, co-pay and /or co-insurance. Additionally, you may be responsible for the portion of our charges that are not covered by your insurance and we recommend that you contact your insurance carrier for further information regarding the costs under your specific plan. Our office will gladly review with you the specifics of your plan benefits.

As a courtesy to our patients, we will bill your insurance company directly for reimbursement for our services, unless other arrangements are made. Occasionally, the insurance company will either mail the check or deposit our reimbursement for surgical fees directly to you. In these circumstances, we kindly request that you mail us a copy of the explanation of benefits (EOB) with the check from your insurance company endorsed by you, or in the case of monies being directly deposited, a check from you in the exact amount stated in the EOB made payable to (physician / practice name). Failure to comply will force your account to become past due. This may result in the amount owed being turned over to a collection agency and this may adversely affect your credit. We thank you for your cooperation in this matter and we are happy to assist you in any way we can.

Payment for cosmetic surgery must be made at least one week prior to the procedure. We do not submit insurance claims for cosmetic surgery. The price you pay for cosmetic surgery will state the surgeon's fee, anesthesia fee (if any) and facility fee on the specified procedural date. When applicable, we will collect fees for the hospital / surgery center and anesthesia group solely for your convenience, and send those fees to the respective people. Collecting fees in no way implies that we take any responsibility for any action taken by either anesthesia or the hospital / surgery center. If you choose, you may pay them directly. Hospital / Surgery center and anesthesia fees are based on an estimate of the time required for your procedure. You may receive a refund for unused time, but it is your responsibility to pursue such a refund. You may be billed for additional time if required. You are responsible for payment if extra time is needed. We are not responsible for that. We may elect, at our own discretion, to assist you with such, but you acknowledge that we bear no responsibility for those refund / additional charges and make no guarantees, implied or otherwise.

I have read the above paragraphs……**Patient Initials** _____**Date:** _____

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We include routine postoperative care for 90 days at no additional cost. Any and all additional treatments including, but not limited to, medications, garments, scar treatments, laser therapy, and/or revisions, that you may need and / or desire are not included in your cost for surgery unless otherwise clearly stated in writing. At our sole discretion and with no implied warranty or guarantee, we may choose to extend your care or provide additional services at no cost or a reduced cost. You should check with your insurance company prior to having cosmetic surgery as some companies have provisions regarding coverage for complications related to cosmetic surgery. If you experience an adverse event, such as an infection, poor wound healing, hematoma or bleeding, blood clot or other situation requiring treatment, whether as an outpatient or in the hospital, such treatments may result in additional charges to you and are not included in the price you pay for cosmetic surgery. We bear no responsibility for charges rendered by the hospital or anesthesia providers.

If you initiate a personal injury lawsuit against another person / entity for injuries sustained, and you received treatment by our practice for those injuries, you agree to notify us immediately when your lawsuit is filed and provide the name and contact information of your attorney. In the event you prevail in your legal proceeding, either by settlement or actual jury verdict, and receive a monetary award, you agree that the remainder of this paragraph will be in full force in the event that a subrogation action occurs. In such a case, your own health insurer will be reimbursed for care. This applies to private / commercial plans as well as Medicare and Medicaid plans. As such, we are not bound by their contracted fee schedules. Thus, our full and non-discounted fees will then apply. The balance owed on your account will then be calculated by subtracting what has already been paid from the total non-discounted amount. You agree to have your lawyer pay us the entire balance from the proceeds of your legal case before you or any other entity is paid.

If your insurance company denies a claim because it is considered medically unnecessary, you will be responsible for full payment. If pre-certification is required prior to surgery, we will obtain authorization on your behalf. If you provide inaccurate insurance information and such renders the authorization invalid, resulting in non-payment, you will be the responsibility for the entire balance. Balances remaining after 45 days will be subject to sixteen percent interest (annually). If payment of our fees is not made in what we consider to be a timely manner your account may be sent to collection, and may be subjected to additional charges and fees associated with such collection.

CANCELLATIONS: Last minute cancellations are disruptive to the practice and result in unused time. We want patients to take the surgery time and date seriously, to avoid these last minute cancellations. We reserve the right to impose the following penalties for last minute cancellations: 25% of the full fee if within 72 hours of the procedure, 50% of the full fee if within 48 hours of the procedure, and forfeiture of the entire fee for cancellation within 24 hours of surgery

SURGICAL REVISIONS: From time to time, a patient may require or desire a surgical revision. Surgical revisions are not included in the price you pay for surgery, whether cosmetic or reconstructive, unless specifically stated in writing ahead of time. Cosmetic revisions are frequently offered at no charge, especially if we can perform such in our office, but this decision lies with each doctor individually and no guarantee whatsoever is made that you will receive free or discounted care. In the event that you require / desire a revision following a procedure that your insurance company initially covered, such doesn't mean that your insurance company will approve the revision. If not approved, you may have the option of proceeding with a cosmetic revision, and the cost will be discussed with you prior to the procedure. Patient non-compliance can have detrimental effects and lead to increased complications and even poor outcomes, whether intentional or not. In such cases, any additional care you receive, whether required or simply desired, may incur additional charges. From time to time, an executive decision can be made to refund or eliminate patient balances as the cost of business and not a reflection on quality or outcome.

I have read the above paragraphs……**Patient Initials** _____**Date:** _____

(May 2020)

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Please provide the names of people with whom we can discuss your personal information and sensitive medical information.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

I acknowledge that I have read the information in this registration packet. I have initialed the preceding 3 pages and have signed this page, acknowledging my acceptance and understanding of the provisions within. I am aware of "my provider(s)" participation status with regard to my insurance company, meaning whether he is an in-network provider or an out-of-network provider, and have had my questions answered to my satisfaction. I elect to obtain services from "my provider(s)". I understand that it is my responsibility to remit any funds rendered to me by my insurance carrier as payment for medical services provided to me by "my provider(s)". Failure to do so may expose me to any applicable civil or criminal penalties. I hereby authorize "my provider(s)" and Associates in Plastic & Aesthetic Surgery to appeal and pursue all other legal rights for any and all unpaid claims on my behalf with my insurance company. I also acknowledge that I have read the above information regarding fee disclosures.

_____ _____ _____

Patient Signature (or authorized person) **Print Name** **Date**

(May 2020)

Charles A. Loguda MD Howard N. Tepper MD Jerrold Zeitels MD Richard Tepper MD

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ASSIGNMENT OF BENEFITS &LIMITED POWER OF ATTORNEY

I, the undersigned, irrevocably assign to Dr. Charles Loguda, Dr. Howard Tepper, Dr. Jerrold Zeitels, and / or Dr. Richard Tepper (known as *"my provider")*, all of my rights and benefits under my insurance contract and/or any employee welfare benefit plan for payment for services rendered to me including, but not limited to, all of my rights and benefits under the **Employee Retirement Income Security Act** ("ERISA") and/or other applicable federal and state laws, applicable to the medical services at issue. This is regardless of the "my provider's" managed care network participation status. I irrevocably authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier/employee welfare benefit plan/ other responsible party, for any and all rights and benefits under ERISA or applicable federal and / or state statute/law, including but not limited to the claim for penalties and fees under ERISA for failure to provide Plan documents and other equitable relief. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills and/or to file insurance claims on my behalf for services rendered to me. I direct that all reimbursable medical payments go directly to you, "my provider". I authorize and consent to your acting on my behalf in this regard and in regard to my general health insurance coverage and I specifically authorize you to pursue any administrative appeals conducted pursuant to ERISA. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize "my provider" to release all medical information necessary to pre-certify a service and / or process my claims under HIPAA, including the release of office records, outside testing or consultation, and digital images obtained during the course of treatment. This information may contain private and/or personally identifiable information.

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this **limited/special power of attorney** and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case, in my name, including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney-in-fact. I further grant limited power of attorney to you as "my provider" to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me. I authorize you and or your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my medical condition. **I authorize you and or your attorney to receive from my insurer, immediately upon verbal request, all information regarding last payment made by said insurer on my claim, including date of payment and balance of benefits remaining.**

In the event that I receive direct payment (i.e. "a check") from my insurance company in any amount for services already rendered by "my provider", I agree to forward immediately to "my provider" such checks, made payable to "my provider" (enter the actual physician name). I agree to include the Explanation of Benefits (EOB) in my possession, and will further keep a photocopy of the check and EOB for my records. I understand that such an insurance check, even if made payable to me, isn't mine and represents the property of "my provider". I understand that failure to release such check may result in a criminal penalty. If you, "my provider", initiate a collection proceeding against me, whether through litigation, arbitration or otherwise, in connection with any and all claims unreimbursed and/or under-reimbursed by my insurance carrier, I agree to pay any and all of "my provider's" attorneys' fees and court fees in connection with that proceeding.

I acknowledges that I been given ample opportunity to read this agreement, ask questions about it, and am\ in full agreement with it. A photocopy of this assignment is to be considered as valid as the original.

Patient Signature (or authorized person)	**Print Name**	**Date**

Charles A. Loguda MD Howard N. Tepper MD Jerrold Zeitels MD Richard Tepper MD *(May 2020)*

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COVID-19 INFORMED CONSENT AGREEMENT

I, the undersigned patient, consent to an in-person consultation and/or to have my Doctor and/or his/her staff (hereinafter collectively "my Doctor") perform medical procedures, whether regarded as necessary, elective or aesthetic, during the time of the COVID-19 pandemic and after. I understand in-person consultations and/or having my procedure performed at this time, despite my own efforts and those of my Doctor, may increase the risk of my exposure to COVID-19. I am aware that exposure to COVID-19 can result in severe illness, intensive therapies, extended intubation and/or ventilator support, life-altering changes to my health, and even death. I am also aware of the possibility that the procedure itself, whether performed in my Doctor's office or in a hospital, may result in a more severe case of COVID-19 than I might have had without the procedure.

I also understand in-person consultations and/or having my procedure performed at this time increases the risk of my transmission of COVID-19 to my Doctor. This virus has a long incubation period, there may be as yet unknown aspects of its transmission, and I realize that I may be contagious, whether or not I have been tested or have symptoms. To reduce the possibility of COVID-19 exposure or transmission at my Doctor's office, I accept that my Doctor will implement infection-control procedures with which I must comply, before, during and after my consultation and/or procedure, for my own protection as well as that of my Doctor. I understand my cooperation is mandatory, whether or not I personally feel such COVID-19 procedures and/or preventive measures are necessary.

I have informed my Doctor of any COVID-19 testing I or any person living with me during the past 14 days has received, as well as the results of that testing, and if I am tested between now and the date of my procedure, I will immediately provide the results of that testing to my Doctor. I understand my Doctor may require that I be tested, possibly at my own expense and regardless of any prior testing, and that the results of that testing must be satisfactory to my Doctor, before I may receive my procedure.

I confirm that neither I nor any individual living with me has any of the COVID-19 symptoms listed by the Centers for Disease Control (https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID19-symptoms.pdf). I have also answered the questions on the next page; neither I nor any individual living with me during the past 14 days has experienced any such symptoms; and that I and all persons living with me for the past 14 days have practiced all personal hygiene, social distancing and other COVID-19 recommendations contained within all governmental orders issued by my city and state. I understand I must honestly disclose this information to avoid putting others and myself at risk.

All COVID topics have been discussed with me, and all my questions have been answered to my satisfaction. Being fully informed, I accept the risk of COVID-19 exposure and I will bear the cost of any COVID-19 treatments required. I have been given the opportunity to postpone my in-person consultation and/or procedure until the COVID-19 pandemic is less prevalent, but I choose to have my in-person consultation and/or procedure performed now. If I am the parent, guardian or conservator of the patient, I hold his/her health care power attorney. I have read this COVID-19 Informed Consent Agreement and am authorized to consent on the patient's behalf.

_____ _____

Patient/Authorized Representative Signature Date

_____

PRINT Patient/Authorized Representative Name

(May 2020)

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Patient Questionnaire during Covid-19

1. Were you ever diagnosed with, or tested for, Covid-19	YES	NO
2. Have you been in contact with anyone who has been sick or tested positive for Covid-19 in the past 14 days	YES	NO
3. Do YOU or SOMEONE YOU LIVE WITH currently have:		
• Fever, cough, sore throat	YES	NO
• Shortness of Breath / difficulty breathing	YES	NO
• Chills or repeating shaking	YES	NO
• Muscle pain or headache	YES	NO
• RECENT loss of taste or smell	YES	NO
• Have you been exposed to someone with Covid-19?	YES	NO
• Any other abnormal symptoms	YES	NO

_____ _____

Patient/Authorized Representative Signature Date

_____

PRINT Patient/Authorized Representative Name

Charles A. Loguda MD Howard N. Tepper MD Jerrold Zeitels MD Richard Tepper MD

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