HEALTHY
COMPLEXIONS SPA
by Western New York Dermatology

COVID 19 Health Questionnaire

Please reschedule if you answer YES to any of the following:

1) Have you shown any symptoms of COVID-19, or come in close contact with anyone exhibiting these symptoms in the past two weeks?

☐ YES ☐ NO

2) Do yo have a cough, fever, chills, headache, shortness of breath, body aches & pains, or loss of taste or smell?

☐ YES ☐ NO

3) Have you been diagnosed with or cared for someone diagnosed with COVID-19 in the past two weeks?

☐ YES ☐ NO

4) Have you traveled outside of your immediate daily routine in the past two weeks?

☐ YES ☐ NO

Print your name _____

Signature _____

Date _____

We treat your skin.
You treat yourself.

297 Spindrift Drive
Williamsville, NY 14221
716.300.1444

HEALTHY
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by Western New York Dermatology

COVID - 19 Risk Informed Consent

Release of liability

I _____ (client/patient name) understand that I am opting for an elective treatment 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 that Dr. Michael Nazareth and all the staff at Healthy Complexions Spa and Western New York Dermatology are 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.
I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure, and I give my express permission for Dr. Michael Nazareth and all the staff at Healthy Complexions Spa and Western New York Dermatology 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 can lead to a higher chance of complication and death.
I understand that possible exposure to COVID-19 before/during/after my treatment 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, 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, 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 itself.
I have been given the option to defer my treatment 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.

By signing, I acknowledge that I have read and understood all of the terms of this agreement and that I am voluntarily giving up substantial legal rights, including the right to sue the company.

Printed Name: _____

Signature: _____

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