COVID-19 RISK INFORMED CONSENT

I _____ (client name) understand that I am opting for an elective treatment that is not urgent and is not 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 Ms. Jodi Holtz and all the staff at The Waxing Studio 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. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment, and I give my express permission for Ms. Holtz and all the staff at The Waxing Studio to proceed with the same.

I understand that possible exposure to COVID-19 before or during my treatment may result in a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, and perhaps hospitalization.

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 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.

☐ Over the past 14 days I have not had any of the following symptoms of possible COVID-19:

- Cough
- Shortness of breath or difficulty breathing
- Chills
- Repeated shaking with chills
- Muscle pain
- Headache
- Known close contact with a person who is lab confirmed to have COVID-19
- Sore throat
- Loss of taste or smell
- Diarrhea
- Feeling feverish or a measured temperature greater than or equal to 100.0 degrees Fahrenheit

☐ I have not traveled outside the State of Texas in the past 21 days

☐ No one in my household has traveled outside the State of Texas in the past 21 days

I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE TREATMENT.

_____

Patient or Person Authorized to Sign for Patient Date/Time

Witness _____Date/Time_____

I have been offered a copy of this consent form (patient's initials) _____