COVID-19 REQUEST FOR TREATMENT REPRESENTATIONS AND CONSENT

I hereby acknowledge and understand that there may be an increased risk the COVID-19 may be transmitted in any place of public accommodation, which includes Lippitz Orthodontic office. I have been informed by my orthodontist office their desire to protect their patients, staff and the community at large. We are taking the necessary precautions necessary to limit the exposure of any virus within our office.

I understand that despite my health care provider's best efforts to identify potential carriers of the virus, we cannot guarantee that we are able to identify such individuals and prevent them from potentially bringing the virus to this office. Despite safeguards instituted to minimize infection, I understand that there is a risk that performing this procedure, and the care associated with it, may result in my becoming infected with the COVID-19 virus. Such infection could further result in significant sickness, disability or death.

As a prerequisite to obtaining the treatment proposed, I am confirming that I have none of the current commonly known symptoms of COVID-19 fever-defined as above 100.4 degrees, cough, shortness of breath, sore throat, loss of taste and/or smell sensation) and that I have not travelled outside my state in the last 14 days. Further, I have been practicing all current CDC guidelines with respect to "social distancing" and have NOT been in contact with a person who had a positive test for COVID-19 or suspected to be positive.

APPOINTMENT INSTRUCTIONS:

1. **Please arrive promptly to your scheduled appointment time.**
2. **Patient's temperature will be taken upon entry.**
3. **Only patient is to enter the building. If parent also enters above prerequisites also apply.**
4. **Teeth are to be brushed at home as our tooth brushing area is closed.**
5. **Patient is to enter, stop to sanitize hands and will be directed where to go for appointment.**
6. **After appointment please call our office to schedule next appointment.**

We have a very limited schedule to reduce the number of patients/staff in the office. Please be patient and understanding as we navigate through these unprecedented times together. Please email or call with any questions.

I hereby consent to the treatment/appointment proposed by my orthodontist.

PATIENT NAME:_____

SIGNATURE (for minor):_____ DATE:_____

Email: lippitzsmiles@aol.com/773-508-5588/847-562-8858