COVID-19 Emergency Treatment Consent and Release of Claims Form

I, _____(the patient), Print name

consent to receive emergency treatment from Montgomery Fertility Center (MFC) and its affiliate Conception Center (CC) during the COVID-19 outbreak.

._____(Initial) I understand there is much to learn about the newly emerged COVID-19, including how it spreads and is transmitted.

._____(Initial) I understand that, based on what is currently known about COVID-19, the spread is thought to occur mostly from person-to-person via respiratory droplets during close contacts.

._____(Initial) I understand that close contact can occur from being within approximately 6 feet of someone with COVID-19 for a period of time, or by having direct contact with infectious secretions from someone with COVID-19.

._____(Initial) I understand that carriers of COVID-19 may not show symptoms but may still be highly contagious. I understand that due to the unknowns of this virus; the number of other patients that have been in the Practice; and the nature of the procedures performed here; that I have a risk of contracting the virus by being in, and by receiving treatment at, Montgomery Fertility Center (MFC) and its affiliate Conception Center (CC).

._____(Initial) I understand that the Center for Disease Control ("CDC") guidelines do not recommend proceeding with any treatment that is non-emergency, and non-urgent at this time.

._____(Initial) I understand that even with the Practice following all the CDC guidelines for infection control of COVID-19 in providing emergency/urgent treatments, that I am still at risk for possible infection with receiving such treatment at Montgomery Fertility Center (MFC) and its affiliate Conception Center (CC) at this time.

._____(Initial) I understand that the treatment I am receiving is an emergency because of the underlying infection, pain, or condition that limits my normal day-to-day activities, or condition(s) that severely compromise future fertility. I confirm I am seeking treatment for a condition that meets these criteria.

_____(Initial) I understand that the symptoms listed below are representative of COVID-19:

- Sore throat
- New loss/reduced sense of taste or smell
- Fever, ≥ 100.0° F (note that temperature cut-off here is arbitrary, but is the value chosen by CDC)
- Cough,
- Shortness of Breath or difficulty breathing
- Chills

- Repeated shaking with chills
- Muscle aches/pain
- Fatigue,
- Headache,
- Runny nose,
- Nausea, vomiting,
- Diarrhea,
- Abdominal pain
- Persistent pain or pressure in the chest,
- Bluish lips or face,
- Headaches.

_____(Initial) I confirm that I, and those who live with me, have not displayed, or currently have, any of the symptoms that are representative of COVID-19, which are outlined above.

_____(Initial) I confirm that, to the best of my knowledge, in the past 14 days I have not come into close contact with anyone who appeared to me as displaying, or having, any of the symptoms that are representative of COVID-19, which are outlined above.

_____(Initial) I confirm, to the best of my knowledge, that I have not had close contact with an individual diagnosed with COVID-19 in the past 14 days.

_____(Initial) I understand that all travelers arriving from a country or region with widespread ongoing transmissions should stay home for 14 days to practice social distancing and monitor their health after their arrival. I confirm that I, and those who live with me, have not returned in the last 14 days from traveling to any of the countries or regions with widespread **ongoing** transmissions, including but not limited to all European countries, Mexico, China, Africa, Canada, India, Bangladesh, and Latin America.

_____(Initial) RELEASE OF CLAIMS I release, that is, I give up and forever relinquish any and all claims, complaints and any legal actions in any court of law, or in any other proceedings before any governmental entity, that I became infected with the coronavirus, or that I suffered any other personal, physical or any other injury as a result of the treatment I have received from Montgomery Fertility Center (MFC) and its affiliate Conception Center (CC) and from all the professional and technical providers who treated me at Montgomery Fertility Center (MFC) and its affiliate Conception Center (CC).

._____(Initial) I understand this release means that I can never bring any claim for any money damages, nor for any other legal remedy/relief against Montgomery Fertility Center (MFC) and its affiliate Conception Center (CC) and any of the professional and technical providers at Montgomery Fertility Center (MFC) and its affiliate Conception Center (CC) .

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._____(Initial) I acknowledge that I have read and understand this Release and that I knowingly and voluntarily have signed it as a condition of Montgomery Fertility Center (MFC) and its affiliate Conception Center (CC) agreeing to provide treatment for me.

Patient Name_____-----
Patient Signature_____----------
Date:_____

Reviewed by Staff Name_____
Signature_____
Date _____

For Practice Use: Doctor: Signature:_____ Date_____