Levy Dental Arts: Dr. Uri Levy, DMD
119 W 57th St. Suite 801, New York, NY 10019
(212) 751-5448

COVID-19 Treatment Consent and Release of Claims Form

I, _____ consent to receive treatment from Dr. Uri Levy and Staff during the **COVID-19** outbreak.

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

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

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 an increased risk of contracting the virus by being in, and by receiving treatment at the practice.

I understand that even with the practice following all the **CDC** and **ADA** guidelines for infection control of **COVID -19** in providing dental treatments that I am still at risk for possible infections with receiving such treatment at the practice at this time. _____ **(Initial)**

I understand that the dental procedures have the potential to include aerosol-generating procedures as well as splashes and sprays, which are some of the ways that **COVID -19** can be spread.

I understand that the symptoms listed below are representative of COVID -19:

- Fever
- Dry Cough
- Shortness of Breath
- Temperature
- Persistent pain or pressure in the chest
- Bluish lips or face

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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 all European countries, China, Korea, 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 dental treatment I have received from the Practice and from all the professional and technical providers who treated me at the Practice. I understand that this release means that I can never bring any claim for any money, damages, nor for any other legal
Remedy/relief against the Practice and any of the professional and technical providers at the Practice.

I acknowledge that I have read and understand this Release and that I knowingly and voluntarily have signed it as a condition of the Practice agreeing to provide treatment for me.

Patient Name: _____
Print
Patient/Guardian Signature: _____

Date: _____

Witness:
Name: _____
Print
Signature: _____

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Date: _____

For Practice Use:

Doctor:

Signature: _____ **Date** _____