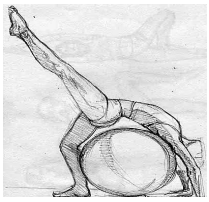

Tannaz Nikravesh, MD

Physical Medicine & Rehabilitation
Regenerative Sports Medicine

6404 Wilshire Blvd., Suite 600
Los Angeles, CA 90048
Office: (310)659-2226
(323)782-8586
Fax: (323)782-8528

Patient Name: Date:
DOB:

INFORMED CONSENT FOR COVID-19 RISK

I ATTEST THAT:

- **I AM NOT EXPERIENCING ANY SYMPTOMS OF ILLNESS SUCH AS COUGH, SHORNESS OF BREATH OR DIFFICULTY BREATHING, FEVER, CHILLS, REPEATED SHAKING WITH CHILLS, MUSCLE PAIN, HEADACHE, SORE THROAT, OR NEW LOSS OF TASTE OR SMELL.**

- **I HAVE NOT TRAVELED INTERNATIONALLY WITHIN THE LAST 14 DAYS**

- **I HAVE NOT TRAVELED TO A HIGHLY IMPACTED AREA WITHIN THE UNITED STATES OF AMERICA IN THE LAST 14 DAYS.**

- **I DO NOT BELIEVE I HAVE BEEN EXPOSED TO SOMEONE WITH A SUSPECTED AND/OR CONFIRMED CASE OF THE CORONAVIRUS/ COVID-19**

- **I HAVE NOT BEEN DIAGNOSED WITH CORONAVIRUS/COVID-19 AND NOT YET CLEARED AS NON CONTAGIOUS BY STATE OR LOCAL PUBLIC HEALTH AUTHORITIES.**

Patient Name:

- **I AM FOLLOWING ALL CDC RECOMMENDED GUIDELINES AS MUCH AS POSSIBLE AND LIMITING MY EXPOSURE TO THE CORONAVIRUS/COVID-19.**

_____Initial

I acknowledge the contagious nature of the Coronavirus/COVID-19 and that the CDC and many other public health authorities still recommend practicing social distancing.

I further acknowledge that Tannaz Nikravesh MD has put in place preventative measures to reduce the spread of the Coronavirus/COVID-19.

I further acknowledge that Tannaz Nikravesh, MD cannot guarantee that I will not become infected with the Coronavirus/COVID-19. I understand that the risk of becoming exposed to and/or infected by the Coronavirus/COVID-19 may result from the actions, omissions, or negligence of myself and others, including, but not limited to, clinical staff, and other patients and their families.

I voluntarily seek services provided by Tannaz Nikravesh, MD at T Nikravesh MD Corporation and acknowledge that I am increasing my risk to exposure to the Coronavirus/COVID-19. I acknowledge that I must comply with all set procedures to reduce the spread while attending my appointment.

I hereby release and agree to hold Tannaz Nikravesh, MD at T Nikravesh, MD Corporation harmless from, and waive on behalf of myself, my heirs, and any personal representatives any and all causes of action, claims, demands, costs, expenses and compensation for damage or loss to myself and/or property that may be caused by any act, or failure to act of the clinic or doctor, or that may otherwise arise in any way in connection with any services received from Tannaz Nikravesh, MD. I understand that this release discharges Tannaz Nikravesh, MD at T Nikravesh, MD Corporation from any liability or claim that I, my heirs, or any personal representatives may have against the clinic or Dr. Nikravesh or her staff with respect to any bodily injury, illness, death, medical treatment, or property damage that may arise from, or in connection to, any services received from Tannaz Nikravesh, MD. This liability waiver and release extends to the clinic together with the physician(s), physician assistants and employees.

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. Tannaz Nikravesh and all the staff at T Nikravesh, MD Corporation are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of the Coronavirus/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 visit/elective treatment/procedure. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective visit/ treatment/procedure, and I give my express permission for Dr. Tannaz Nikravesh and all the staff at T Nikravesh, MD Corporation to proceed with the same.

_____Initial

I understand that possible exposure to the Coronavirus/COVID-19 before/during/after my visit/treatment/procedure 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 visit/treatment/procedure, I may need additional care that may require me to go to an emergency room or a hospital.

I understand that the Coronavirus/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 visit/treatment/procedure itself.

_____ _____

Name (PRINT) Signature

_____

Date

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