

AESTHETIC DENTAL GROUP
1794 Washington Valley Road
Martinsville, New Jersey 08836

COVID-19 Patient Consent to Screening/Examination; Acknowledgment of Practice Rights

Patients MUST complete this form and undergo medical observation/examination each time they present at the office BEFORE any treatment.

A. Patient Acknowledgment. I acknowledge my understanding that the symptoms listed below are representative of COVID-19:

- Fever (chills, sweating)
- Temperature
- Dry Cough
- Sore Throat
- Runny Nose
- Shortness of Breath (not necessarily severe)
- Lost or reduced sense of smell
- Persistent pain or pressure in the chest
- Bluish lips or face

B. Patient Confirmations. In making this request for elective dental services, I confirm the truth of all the following:

- (1) I do not now, and have not in the past 14 days, exhibited any of the signs or symptoms which are representative of COVID-19, as listed above ____ (Initial);
- (2) I have not, in the past 48 hours, taken any fever reducing or any other symptom-reducing medications (e.g. cough suppressants) ____ (Initial);
- (3) I have not tested positive for COVID-19 ____ (Initial);
- (4) I am not waiting for COVID-19 test results ____ (Initial);
- (5) At all times I have complied with, and will continue to comply with, until they are rescinded, all the stay-at-home, social distancing, wearing masks, and all other COVID-19 related emergency orders issued by the State of New Jersey ____ (Initial);
- (6) I, and those who live with me, have not exhibited, or currently have, any of the signs or symptoms that are representative of COVID-19, as listed above ____ (Initial);
- (7) Those who live with me have not tested positive for COVID-19 and none of them are waiting for COVID-19 test results ____ (Initial);

- (8) 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 signs or symptoms that are representative of COVID-19, as listed above, or who has tested positive or is awaiting test results for COVID-19 ____ (Initial);
- (9) To the best of my knowledge, in the past 14 days I have not had close contact with an individual otherwise diagnosed with COVID-19, or who has been released from the hospital after having recovered from COVID-19 ____ (Initial); and
- (10) I will immediately notify the Practice if, within 14 days after my office visit, I, or anyone who lives with me, experiences the signs and symptoms of COVID-19 as listed above, or tests positive for the virus ____ (Initial).

C. Patient Consents. I consent to the following:

- (1) To provide the Practice with all relevant health information on whether I am in a high-risk category for infection with COVID-19. (High-risk categories include those individuals who have respiratory, pulmonary, or heart conditions, high blood pressure, immune deficiencies, or compromised immune systems (a compromised immune system can be caused by, among other conditions, diabetes, asthma, COPD, cancer treatment, radiation therapy, chemotherapy, or the taking of any medication which compromises the immune system); and this category also includes those individuals who are pregnant or over age 60);

(I fully understand and acknowledge the heightened risks involved with having elective dental treatment during the pandemic with my being in a high-risk category for infection with COVID-19. I have accurately and fully disclosed to the Practice any health condition which may result in my having a compromised immune system, or which otherwise places me in a high-risk category for becoming infected with the COVID-19 virus. ____ Initial)
- (2) To permit a Practice health care provider to observe and screen me for the above listed representative signs and symptoms of COVID-19;
- (3) To undergo a medical examination by a Practice health care provider which will include taking my temperature and a pulse oximeter test for the oxygen level in my blood (this test is non-invasive and only involves a clip placed on my finger for this measurement).

The health information the patient provides in response to this Patient Consent, and the results of the medical examination, will be maintained by the Practice in the patient's clinical file.

D. Practice Acknowledgment and Reservation of Rights.

- (1) Practice Acknowledgment. The Practice acknowledges that the health information it obtains from the patient under Section C, Patient Consent, above, will be used, maintained and disclosed, in accordance with the Practice's Notice of Privacy Practices, as required

by the Health Insurance Portability and Accountability Act of 1996, which Notice was previously provided to the patient.

- (2) Reservation of Rights. After assessing the personal health and other information the patient has provided in completing this form; the results of the patient's medical screening/observation and examination; and after considering the type of elective procedures the patient will require (e.g. high aerosol and/or water generating spray); the Practice staff may conclude, in the discretionary exercise of its professional judgment, that providing treatment at this time would create an unacceptable risk of infection to the patient, and/or other patients, or the Practice's staff. In such situation, the Practice will offer the patient the first available appointment after the Practice has determined that such risk has been reduced to an acceptable level in the Practice's discretionary exercise of its professional judgment.

I confirm that I: (a) have fully and accurately provided the confirmations and health information requested from me in Section B, Patient Confirmations, and Section C, Patient Consents; (b) have voluntarily consented to the screening and medical testing for the symptoms of COVID-19, as also provided in Section C; and (c) have knowingly and voluntarily consented to the Practice's reservation of its right to decline to treat me at this time, as provided in Section D(2), Reservation of Rights.

I further confirm I am seeking elective dental treatment. I understand and accept the additional risk of contracting COVID-19 from having such treatment at the Practice's office at this time. I also acknowledge that I could contract the COVID-19 virus from outside this office and unrelated to my visit to it.

Patient Name: _____
Print

Signature

Patient/Guardian: _____
Print

Signature

Date: _____

Practice Witness:

Name: _____
Print

Signature

Title

Date: _____

For Practice Use: AESTHETIC DENTAL GROUP

Signature: _____ Date _____
DR. JOHN CROSS, DMD

AESTHETIC DENTAL GROUP
1794 Washington Valley Road
Martinsville, New Jersey 08836

COVID-19 Patient Acknowledgments, Release of Claims; Consent to Arbitration

I, _____ (the patient),
Print name

acknowledge my understanding that the State of New Jersey is now permitting dentists to provide elective dental services during the COVID-19 pandemic which the dentist, in his/her professional judgment, can safely perform. I have requested that the Practice provide such services for me.

A. Patient Acknowledgments. In making this request for such services during the pandemic, I acknowledge my understanding of all the following:

- (1) the COVID-19 virus spreads mostly from person-to-person via respiratory droplets during close contacts;
- (2) close contact can occur from being within approximately 6 feet of someone with COVID-19 for even a short period of time, or by having direct contact with infectious secretions from someone with COVID-19;
- (3) droplets containing the virus can remain airborne for hours and, when they land on any surface, can remain active and infectious perhaps for days;
- (4) the COVID-19 virus has a long incubation period, and an individual may have the virus and not show symptoms but still be highly contagious;
- (5) due to the unknowns of this virus; the number and frequency of other patients that will be in the Practice offices; and the characteristics of the procedures performed here; there is an increased risk of contracting the virus by being in, and by receiving treatment at, the Practice;
- (6) dental procedures have the potential to include aerosol-generating procedures as well as anticipated splashes and sprays, which are some of the ways that COVID-19 can be spread;
- (7) determining who is infected by COVID-19 is challenging and complicated due to the still limited availability of virus testing;
- (8) at this time, the Center for Disease Control (“CDC”) and American Dental Association (“ADA”) guidelines still do not recommend proceeding with all elective dental procedures;
- (9) even with the Practice following all the CDC, ADA, State of New Jersey Dental Association and State of New Jersey Department of Health, guidelines for infection control of COVID-19 in providing dental treatments; I am still at risk for possible infection with receiving elective treatment at the Practice at this time ____ (Initial);

(10) even with all the Practice staff correctly using all the Personal Protection Equipment recommended by the above-listed government agencies and professional organizations, I am still at risk for possible COVID-19 infection with receiving elective dental treatment at this time ____ (Initial);

(11) the treatment I am receiving is elective because, upon examination by my treating dentist I have been told, and I agree, that I do not have an underlying infection, pain, or dental condition that limits my normal day-to-day activities, but I do have a dental condition which, if not treated now, will continue to get worse; and

(12) I confirm I am seeking treatment for an elective procedure ____ (Initial).

B. Release of Claims

I release, that is, I give up and forever relinquish any and all disputes, claims, controversies, complaints, charges, and any causes of legal actions, in any court of law or in any other proceedings before any governmental entity, that I became infected with the COVID-19 virus, or that I suffered any other personal, physical or any other injury as a result of the elective dental treatment I have received from the Practice and from all the professional and technical providers who treated me at the Practice.

I understand 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 as a result of the elective dental treatment I have received.

As a condition of the Practice agreeing to provide elective dental treatment for me during the COVID-19 pandemic, I acknowledge that I have read and understand this Release; that I knowingly and voluntarily have agreed to it and; that if I did ask any questions about it, they have all been answered to my satisfaction. ____ Initial

C. Consent to Arbitration.

Applicability.

In the event that for any reason, or in any circumstances, the above Release of Claims is found to be invalid and/or otherwise not enforceable, in whole or in part, then the following terms for arbitration shall apply.

Definitions.

Patient is defined to include the individual who actually receives treatment by the Practice and, for a minor patient, their parent or guardian who executes this document.

Practice is defined to include the Practice as a legal entity, and all its owners, members, officers, executives, managers, supervisors, employees and independent contractors and contractors.

Party/Parties is defined to include Patient and Practice as defined above.

Agreement to Arbitration.

All disputes, claims, controversies, complaints, charges, and causes of legal action in any court of law, or any administrative law action (hereinafter collectively referenced as "Claims"), which arise out of, are related to, or are connected with, either directly or indirectly, or in whole or in part, the business\professional relationship between the Practice and Patient, including, but not limited to, all treatment and care provided by the Practice for the Patient, and the billing and collection for same, and further including all Claims of malpractice or any other allegations of personal, physical or any other injury as a result of the treatment provided by the Practice, and any Claims of any other misconduct/wrongdoing by the Practice, shall all be adjudicated and finally resolved exclusively through final and binding arbitration before one arbitrator.

The arbitrator shall be selected and shall decide the Claim(s) through the procedures for commercial arbitration provided by JAMS, (Judicial Arbitration and Mediation Services), headquartered at 45 Broadway, New York, New York 10006. The JAMS rules for commercial arbitration can be found at www.jamsadr.com.

This Agreement for arbitration includes having the arbitrator determine the enforceability of this arbitration provision, its applicability to, and the arbitrability of, any particular Claim(s), whether this provision for arbitration was properly invoked by a Party, and any and all other questions, disputes or issues relating to the use of this arbitration process as the only means to adjudicate and finally resolve any Claim(s) between the Parties.

The Parties acknowledge their understanding that under this provision for arbitration, they are waiving (giving-up) their rights to pursue the adjudication and resolution of any Claim(s) between them through a lawsuit in a court of law with a judge and a trial with a jury.

If for any reason this agreement for arbitration is determined by any court to be unenforceable, and, as a result of such determination, any Claim(s) is adjudicated and resolved in a court of law; then the Parties agree to waive (give-up) their right to have any such Claim(s) tried before a jury, and all such Claims shall be decided by a judge sitting without a jury.

As a condition of the Practice agreeing to provide elective dental treatment for me during the COVID-19 pandemic, I acknowledge that I have read and understand the above sections on Arbitration; that I knowingly and voluntarily agree to all of them; and that if I did ask any questions about them, they have all been answered to my satisfaction ____ Initial.

I confirm that I: (a) have read and understand all the information the Practice has provided in this document; (b) have been fully informed as to all the COVID-19 risks of infection in proceeding with elective dental treatment at this time, as listed in Section A, Patient Acknowledgments; (c) have knowingly and voluntarily, with informed consent, agreed to the Release of Claims, Section B of this document; and (d) have knowingly and voluntarily consented to the arbitration of all

"Claims" I may have against the Practice, as defined in Section C of this document, Consent to Arbitration.

I further confirm I am seeking elective dental treatment. I understand and accept the additional risk of contracting COVID-19 from having such elective dental treatment at the Practice's office at this time. I also acknowledge that I could contract the COVID-19 virus from outside this office and unrelated to my visit to it.

Patient Name: _____
Print

Signature

Patient/Guardian: _____
Print

Signature

Date: _____

Practice Witness:

Name: _____
Print

Signature

Title

Date: _____

For Practice Use: AESTHETIC DENTAL GROUP

Signature: _____ Date _____
DR. JOHN CROSS, DMD