**Instructions for Use of Consent to Treat During COVID-19 Pandemic**

Many are seeking consent forms specific to providing treatment during the COVID-19 pandemic. To our knowledge, it is not a requirement in the states where Physicians Insurance provides coverage. However, our best risk advice is to implement a “consent to treat” form, prior to patient care, as you resume non-emergent and elective care for your patients. Please consider the following suggestions for implementation.

1. Provide patient access to this form prior to the appointment. This is ideal and may be accomplished via secured email correspondence or patient portal. If neither of these methods are available, consider the following alternative methods:
2. Unsecured email, with patient’s permission
3. Posting to practice website for download
4. Facsimile
5. Standard mail, time permitting
6. In the event the document cannot be reviewed, signed, and obtained prior to the appointment, a telephone conversation to discuss its content with the patient can occur. The patient’s understanding of the risk for receiving care during the COVID-19 pandemic should be documented, along with agreement to move forward. Questions raised and answered should also be documented.
7. Regardless of the method to obtain consent to treat, the patient must be given time to ask questions and obtain answers from the provider. Most importantly, the risk of delaying care should be addressed with the patient and documented in the medical record. Documentation should also include the patient’s questions, provider responses, and decision to move forward with or delay care.
8. The signed form should be entered into the patient’s medical record.

It is our recommendation to ensure that the consent form is at an appropriate health literacy level. The example form provided here has been developed at a 7th grade health literacy level.

**Consent to Treat During COVID-19 Pandemic**

**DISCLAIMER**: The information contained in this sample policy/procedure or form is not legal advice but is rather intended to provide guidance for members in developing their own policy/procedure and forms. Members should make sure any policy/procedure or form that is adopted is appropriately customized to specifically address the circumstances and practices of the member.*NOTE: Remove this disclaimer and the Physicians Insurance footer prior to adopting this policy/procedure or form.*

I **[insert patient name]** am choosing to get health care that is elective and non-emergent.

I understand that I am getting care during the COVID-19 pandemic. It is easy for COVID-19 to spread from person to person. I am aware that the government recommends social distancing (keeping distance from others) to avoid this spread.

While **[insert name of practice or facility]** follows state and federal infection control guidelines to stop spreading COVID-19, I know that I could still become infected by others who are present during my treatment. Those present may or may not know they are infected, and this adds a risk to moving forward with care.

By reading this form, I know that **[insert name of practice or facility]** is taking these measures to protect patients and staff from COVID-19:

* Carefully choosing patients for elective care
* Social distancing when possible
* Screening staff and patients ahead of time
* Using Personal Protective Equipment (PPE)
* Infection control cleaning based on state and federal recommendations

Knowing the risks, I would like to move forward with my treatment. I have been given the choice to receive care at a later time. I am aware that I can talk about this option with my provider.

I confirm that I have read and understand this form. I have been given the chance to ask questions. My questions have been fully answered.

Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_ Time: \_\_\_\_\_\_

­­­­­­­­­­­­­­­­­­­­­­­­­Patient or Legal Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_Time: \_\_\_\_\_\_

Representative’s Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interpreter: [ ] No [ ] Yes: Interpreter Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_