LONG ISLAND IVF

PATIENT CONSENT FOR TREATMENT DURING THE COVID-19 PANDEMIC

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Print Patient Full Legal Name

Unique Identifier *(Social Security No.)*
(Or DOB (MM/DD/YYYY) if none)

The care team at **RMA Long Island IVF** ("Clinic") and I have discussed the impact that COVID-19 could have on my treatment and on pregnancy.

By signing below, I am acknowledging that I agree and understand that:

a. This pandemic has created a situation in flux, and I am aware that I should review the CDC website for up-to-date information at: https://www.cdc.gov/coronavirus/2019-ncov/index.html
I am encouraged to speak to my nurse or physician about any concerns I have regarding COVID-19 and how it and treatment guidelines may impact my treatment.

b. Information is being gathered by the scientific community to understand the risks of COVID-19 to me and to my pregnancy.
   i. There are risks to my health if I acquire COVID-19 while pregnant. These risks include a more serious form of infection that can lead to severe pneumonia, blood clotting and organ damage that may result in life threatening complications. The Clinic cannot quantify the risk of developing a serious complication.
   ii. The risks to pregnancy may include transmission of the virus from me to the fetus, miscarriage, stillbirth, preterm birth, and/or birth defects. The risk to the fetus cannot be quantified at this time.

c. Medical care inherently requires breaking social-distancing guidelines, and there is a risk of transmission of COVID-19 during travel to and from the office and at my office visit.

d. Obtaining emergency medical care, if needed, may be challenging during the pandemic due to an overburdened health care system.

e. I understand that my cycle may have to be canceled if:
   i. I become directly exposed to COVID-19, am diagnosed with COVID-19, or become symptomatic with any illness that is suspected to be COVID-19 (even in the absence of a positive COVID-19 test).
   ii. The cycle cannot be safely completed due to COVID-19 related staffing shortages, supply shortages, infection risk, or government mandate to cease clinical activities.

f. In the event that treatment is cancelled for any reason before its conclusion, I understand I am responsible for all expenses that I have incurred for care that was rendered.

Having considered all of the above potential risks of treatment and non-treatment, and having had the opportunity to address my questions and concerns with my physician and/or nurse, I have decided to proceed with treatment and hereby give my informed and considered consent to do so.

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Print Patient Full Legal Name

_____ _____

Patient Signature Date (MM/DD/YYYY)