

Columbia Implants & Periodontics
Practice Limited to Periodontics
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DENTAL PATIENT CONSENT AND RELEASE REGARDING COVID-19

Novel Coronavirus (“COVID-19”) has had wide-ranging impacts on our everyday lives, including here at Columbia Implants and Periodontics, the office of Dr. Beaini (“The Practice”). As we transition back to providing dental care, the health and safety of staff and patients remains our top priority.

Precautions. The Practice has implemented, as appropriate, the Center for Disease Control’s (“CDC”) Guidance on Returning to Work as well as guidance by state and local health departments, and applicable state licensing agencies (“the Precautions”). Some of the Precautions may include: regular screening of employees and pre-appointment screening of patients for respiratory illness indicators; limiting non-patient visitors to essential ones such as suppliers and barring family members and friends of patients as appropriate; practicing social distancing with staff and patients where possible; expanding the wearing of masks and other Personal Protective Equipment (“PPE”); rigorous cleaning and sanitizing of our work space, tools, and instruments; responding quickly and effectively to isolate exposed areas and people when a staff member or patient becomes sick; and, making reasonable efforts to assist with contact tracing and notifications where appropriate. Additionally, because dental procedures which use dental instruments such as handpieces, ultrasonic scalers, and air-water syringes create a spray which may contain contaminated droplets and aerosols, some of the Precautions may include transmission-based precautions published by the CDC and/or state licensing agencies, in addition to standard precautions. As guidance and circumstances change so may The Practice’s Precautions.

Consent. By signing this form, I acknowledge and understand that the implementation of some of the Precautions may change as circumstances warrant and that due to the nature of COVID-19, The Practice does not guarantee I will not be exposed to COVID-19 or expose others if I unknowingly have COVID-19. Despite the risk that I could unintentionally be exposed to COVID-19 at The Practice, I agree and consent to receiving dental care at The Practice. If I have questions about the Precautions in place, I understand The Practice will answer them to the best of its ability.

RELEASE. In consideration for the Precautions taken by The Practice to reduce my risk of possible exposure to COVID-19, in consideration for receiving dental care at The Practice, and in consideration of the risk posed to The Practice and its staff in providing me dental care if I unknowingly have COVID-19, **I hereby knowingly and voluntarily RELEASE AND FOREVER DISCHARGE (for myself, my heirs, executors, administrators, and assigns) The Practice (its present and former owners, officers, directors, providers, employees, agents, and representatives (including any volunteers), successors and assigns, any affiliates, and its direct or indirect**

owners), from any and all liability, claims, suits, actions, causes of action, crossclaims, counter-claims, compensatory damages, liquidated damages, punitive or exemplary damages, other damages, claims for costs and attorney's fees, or liabilities of any nature whatsoever and demands of whatever kind or nature, either in law or in equity, for or because of any illness and injury I might incur from unintended exposure to COVID-19 while I am at The Practice and because of any negligence or fault of The Practice arising directly or indirectly from the Precautions.

In executing this document, IT IS MY INTENT to release all claims of any kind or character, including negligence claims, which I might have now or in the future against The Practice arising out of any illness or injury I might incur from unintended exposure to COVID-19 at The Practice and from any because of any negligence or fault of The Practice arising directly or indirectly from the Precautions.

I have read the above. I fully understand it, and my questions have been answered to my satisfaction.

Patient Signature (or Signature of Person Completing Form if Not Patient*) Date

*Relationship to patient: Parent Legal Guardian Other:

Witness Date