KURT C. LAUNEY, DDS

761 WRIGHT AVENUE
GRETNA, LA 70056
504.362.5975

Informed Consent and COVID-19 Addendum

I, the undersigned, understand that as a patient I have the right to be informed about the diagnosis, the recommended treatments and associated risks / complications in order to best make an informed decision regarding my care. I authorize Dr. Launey and/or Dr. Launey's qualified office staff member to use all diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize Dr. Launey and/or his qualified staff member to perform the treatment, medication and therapy that may be indicated to establish my optimum dental health. I understand that certain risks are associated with any dental treatment, and that the use of anesthetic agents (whether local anesthesia or nitrous oxide analgesia) embodies a degree of risk.

I acknowledge that I am responsible for the costs of my dental treatment. I understand that Dr. Launey's office will file my insurance as a courtesy, and that I am responsible for any unpaid balance after my insurance benefits have been applied. I give my authorization to be contacted by a phone landline, pre-recorded/artificial voice message and/or an automatic dialing device or wireless means such as a cell phone or email in connection with any communications regarding my account. I agree to pay all charges and any additional costs (court cost, attorney fees, late fees, interest and/or collections costs) if any are associated with an unpaid balance.

I understand that it is Dr. Launey's office policy that I must give 24 hours advance notice for missing an appointment, and that failing to give such notice could result in a missed appointment fee.

Patient: ________________________________

Date: ________________________________

Parent/Responsible Party: ________________________________
(Signature)

Relationship to Patient: ________________________________

Patient Advisory and Acknowledgement

Receiving Dental Treatment During the COVID-19 Pandemic

You have presented to the office today because you have a dental condition which cannot be postponed until the current COVID-19 risk period abates. Please be advised of the following:

> While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.
>
> Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.
>
> I understand that receiving dental treatment during the COVID-19 pandemic comes with an increased level of risk of contracting the disease and I authorize Dr. Launey and/or his qualified staff members to perform dental treatment on me at this time.

PLEASE ANSWER “YES” OR “NO” WITH YOUR INITIALS, TO THE FOLLOWING QUESTIONS:

ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST?

DO YOU HAVE A FEVER?

DO YOU HAVE ANY SHORTNESS OF BREATH?

DO YOU HAVE A DRY COUGH?

DO YOU HAVE A RUNNY NOSE?

DO YOU HAVE A SORE THROAT?

DO YOU HAVE SNEEZING, WATERY EYS, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES?

HAVE YOU EXPERIENCE HEADACHES, FATIGUE, OR WEAKNESS?

HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL?

WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED TO ANY FOREIGN COUNTRY?

WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED WITHIN THE UNITED STATES?
IF SO, WHERE? ____

A PPE fee will be charged each visit to offset the enhanced protective measures we are taking to keep you safe during the COVID-19 pandemic.

Parent/Responsible Party: ______________________________ Date: ____________

(Signature)