

CONSENT FOR TREATMENT

COVID-19 Antibody Testing

PURPOSE AND BACKGROUND

As a patient of Nourished MedSpa and Wellness Center, I have requested COVID-19 antibody testing, which is used to evaluate the presence of my own antibodies to the coronavirus. I have been informed that the novel coronavirus, or SARS-CoV-2, that causes COVID-19 is one of a family of seven coronaviruses that can infect humans. Three have caused serious outbreaks – SARS coronavirus in 2002, MERS coronavirus beginning in 2012 and now SARS-CoV-2, while the other four cause common colds. This new coronavirus shares 88% of its genetic sequence with SARS coronavirus. I understand that a finger poke blood test will be method of testing for antibodies.

After having a viral infection such as COVID-19, our immune system responds with the production of antibodies. There are different types of antibodies, such as immunoglobulin G (IgG), immunoglobulin M (IgM), and immunoglobulin E (IgE). These antibodies appear at different times during an infection, are found in different parts of the body, and may do very different jobs. For instance, IgE is the antibody we usually associate with allergic reactions rather than viruses or bacteria, and IgA is found in mucosal tissue, like the respiratory system and gastrointestinal tract. And while IgM is the main antibody responsible for clearing a pathogen from the body, IgG is the one that usually handles immunity from future infections.

IgG antibody generally becomes positive and remains positive approximately two weeks after COVID-19 infection. Often these antibodies remain detectable for a prolonged period. At this time, it is unclear if this will be true for COVID-19 infection. With many other viruses, the presence of the antibody appears to confer immunity to the virus, but this is not yet known with the COVID-19 virus. To further complicate matters, the presence of the antibody may not confirm a patient had COVID-19, as there is known cross-reactivity with other coronavirus. This will result in a false-positive test. Without knowing if I ever had COVID-19, the presence of the COVID-19 antibody does not provide certainty of a COVID-19 infection. On the other hand, a negative level tells me either I have not been exposed to COVID-19 or my exposure was too recent (within the last 14 days) and my body has not had time to produce the antibody. I understand that this is not COVID-19 diagnostic testing and that positive test results do not confirm infection or immunity.

Additionally, I understand that I shouldn't make decisions about going to work or crowded places based on the results of one positive antibody test. I may or may not be infectious and never develop symptoms. Researchers are still determining what antibodies mean for the strength of immunity to COVID-19 or how long such immunity might last. No test is 100% accurate and I may have a false positive or false negative test today.

PROCEDURE

One drop of blood is required as the sample. A disposable lancet will be placed against a finger of my choice and used to poke my finger to obtain the blood sample. The drop of blood is placed on the test strip and the results are read between 10 and 20 minutes. Readings after 20 minutes may give false results.

RISKS AND COMPLICATIONS

• Mild pain and tenderness at the injection site

BENEFITS

For the most part, an antibody test can tell a patient with a fairly reasonable amount of certainty whether or not they've had the virus. Specifically, the test will look for the presence of IgG, which appears later or after the infection, as opposed to IgM, which appears earlier in the infection. While the presence of IgM might tell you if someone currently has an infection, the presence of IgG is more likely to tell you that they've had the infection in the past and made a recovery. IgM is detectable within a week or two after the onset of symptoms, at which point someone usually knows whether or not they have more severe symptoms. And IgG is detectable starting between 14 and 21 days after the onset of symptoms.

ALTERNATIVES

This is strictly a voluntary procedure. No treatment is necessary or required. I am not required to undergo testing. I understand that the results of this test will not dictate whether or not I continue to participate in social-distancing, hand-washing or wearing personal protective equipment.

QUESTIONS

This procedure has been explained to me by the staff of Nourished MedSpa and Wellness Center. I have had an opportunity to ask any questions and research the procedure to my satisfaction.

CONSENT

I understand that my consent and authorization for this procedure is strictly voluntary. I have already read and signed the Clinic's general consent and understand that it is still in effect. By signing this informed consent form, I hereby grant authority to Nourished MedSpa and Wellness Center and Dr. Jason Carter, MD (or other delegated medical providers for Nourished MedSpa and Wellness Center) to perform COVID-19 antibody testing and/or administer any related treatment as may be deemed necessary or advisable in the diagnosis and treatment of my condition. For purposes of advancing medical education, I consent to the admittance of observers to the treatment room.

The nature and purpose of this procedure and the complications and side effects have been fully explained to me. Alternative treatments and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment. I agree to adhere to all safety precautions and instructions after the treatment. I have been instructed in and understand post treatment instructions and have been given a written copy of them. I understand that no refunds will be given for treatments received. No guarantee has been given or implied by anyone as to the results that may be obtained from this treatment.

I have read this informed consent and certify that I understand its contents in full. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. I have had enough time to consider the information given me by my physician/practitioner and feel that I am sufficiently advised to consent to this procedure. I accept the risks and complications of the procedure. I certify that if I have any changes occur in my medical history I will notify Nourished MedSpa and Wellness Center immediately.

I hereby voluntarily consent to this procedure and release Nourished MedSpa and Wellness Center, medical staff, and all associated professionals from liability associated with the procedure. I certify that I am a competent adult of at least 18 years of age and am not under the influence of alcohol or drugs. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns.

Patient Name (please print)	Patient Signature	Date
Performed by (please print name and title)	Practitioner Signature	Date



CONSENT FOR TREATMENT

COVID-19 Antigen Testing

PURPOSE AND BACKGROUND

I consent to COVID-19 antigen testing, which is used to evaluate the presence of an active coronavirus infection. Submitting to testing does not make me a patient of Nourished MedSpa and Wellness Center nor does testing create a patient-physician relationship with Dr. Carter. The test detects protein antigens specific to SARS-CoV-2 from individuals who are suspected of COVID-19 within the first five days of symptom onset. I understand that a nasal swab will be the method of testing for coronavirus. Additionally, I understand that I shouldn't make decisions about going to work or being in crowded places based on the results of testing. No test is 100% accurate and I may have a false positive or false negative test today. I understand that I should keep a careful watch on my symptoms as well.

PROCEDURE

Placement of a swab in the back of my nose is required to collect the sample. The results are read between 10 and 15 minutes. Readings after 15 minutes may give false results.

RISKS AND COMPLICATIONS

Mild pain and tenderness at the back of the nose including some bleeding in rare cases.

BENEFITS

The testing offered has an 88.37% positive percent agreement and 100% negative percent agreement with a known specimen. In other words, when the known specimen was positive, this test had a false-negative percentage of 11.63%. When the known specimen was negative, this test was negative 100% of the time.

ALTERNATIVES

This is strictly a voluntary procedure. No treatment is necessary or required. I am not required to undergo testing. I understand that the results of this test will not dictate whether or not I continue to participate in social-distancing, hand-washing or wearing personal protective equipment.

QUESTIONS

This procedure has been explained to me by the staff of Nourished MedSpa and Wellness Center. I have had an opportunity to ask any questions and research the procedure to my satisfaction.

CONSENT

The nature and purpose of this procedure and the complications and side effects have been fully explained to me. Alternative treatments and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment. I agree to adhere to all safety precautions and instructions after the treatment. I have been instructed in and understand post treatment instructions. I understand that no refunds will be given after testing has begun. No guarantee has been given or implied by anyone as to the results that may be obtained from this treatment. I accept any risks and/or complications of the procedure.

I hereby voluntarily consent to this procedure and release Nourished MedSpa and Wellness Center, medical staff, and all associated professionals from liability associated with the procedure. I certify that I am a competent adult of at least 18 years of age and am not under the influence of alcohol or drugs. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns.

Patient Name (please print)

Patient Signature

Date

Performed by (please print name and title)

Practitioner Signature

Date



COVID-19 Antigen Testing

Name:	DOB:	Age:
Address:	Phone:	

Do you have any of the following symptoms? (check all that apply)

Fever or chills Cough Shortness of breath or difficulty breathing Fatigue Muscle or body aches Headache New loss of taste or smell Sore throat Congestion or runny nose Nausea or vomiting Diarrhea

Have you had any signs or symptoms of a fever in the past 24 hours such as chills, sweats, felt feverish or had a temperature that is elevated for you/100.4F or greater?

Yes No

Are you living with, or caring for someone who has symptoms of COVID-19?

Yes No

Are you living with, or caring for someone who has tested positive for COVID-19 within the last 14 days?

Yes No