

Patient Name: _____

Date: _____

Patient Advisory and Acknowledgement regarding Receiving Medical Treatment During Covid-19 Pandemic

Dear Patient: You have come to our office today for a routine medical evaluation and/or treatment that will be done during the COVID-19 pandemic. 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. The practitioner you are seeing today is symptom-free and, to the best of her knowledge, has 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. In order to reduce the risk of spreading COVID-19, we developed a screening questionnaire. Per Governor Brown's order, and for the safety of other patients and practitioners, you are asked to wear a mask in indoor public spaces. Please bring your own from home (homemade masks are acceptable).

Please answer the following questions. Check all boxes that apply:

Exposure to person with a lab-confirmed case of COVID-19 within the past 14 days

In the last 48 hours, have you experienced:

- Fever over 100.5°F/38°C Current temperature _____
- New cough, shortness of breath, or difficulty breathing
- New loss of sense of smell or change in taste

If you check any of the boxes above, unfortunately we cannot treat you at this time. We will be happy to offer a telehealth consult, and/or refer you to an appropriate facility.

In the last 48 hours, have you experienced:

- New changes in skin (rash, skin discoloration, discoloration of toes)
- New chills, feeling cold, or shivering
- New headache
- New fatigue
- Sore throat
- Nausea/vomiting
- Diarrhea
- New nasal congestion or runny nose
- New body or muscle aches

If you check three (3) or more boxes above, unfortunately we cannot treat you at this time. We will be happy to offer a telehealth consult, and/or refer you to an appropriate facility.

I acknowledge that the information provided above is correct:

Signed: _____

Date: _____

While on the premises of the clinic, I agree to:

(Please Initial)

- _____ Maintain a distance of six (6) feet from other persons whenever possible.
- _____ Wear a face mask, and to not remove the mask except when directed by staff.
- _____ Wash my hands for 20 seconds or use hand sanitizer according to CDC guidelines before and after checking in/out at the front desk, before and after my treatment, before and after using the restroom, and to maintain hand hygiene at other times by using hand sanitizer, or washing for 20 seconds.
- _____ To practice proper cough & sneeze etiquette by coughing/sneezing into my elbow, and to give warning to others if I am about to cough or sneeze, so that they can maintain a safe distance.
- _____ Arrive at or shortly before my appointment time and remain in areas designated for my visit, and to not wander about the facility. If am early to the clinic, I will wait in my vehicle.
- _____ Immediately contact **Julie** @ 503.701.3042 if I develop symptoms of COVID-19 within fourteen (14) days of my last visit.