PATIENT ADVISORY AND ACKNOWLEDGMENT
Receiving Treatment During the COVID-19 Pandemic

Dear Patient:

You have presented to the office today because you have a condition which you must be treated for or you are receiving maintenance therapy which you understand is elective. Please be advised of the following:

While our office complies with State Health Department and the Center for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.

Our staff is symptom-free and to the best of their 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 have asked you a number of "screening" questions, below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

_____ _____ _____
Print Name Patient /Responsible Party **Signature** **Date**

DO YOU HAVE A FEVER OR HAVE YOU FELT FEVERISH RECENTLY?	_____ Yes _____ No
DO YOU HAVE ANY SHORTNESS OF BREATH OR DIFFICULTY BREATHING?	_____ Yes _____ No
DO YOU HAVE A DRY COUGH?	_____ Yes _____ No
DO YOU HAVE FLU-LIKE SYMPTOMS, SUCH AS THE CHILLS, GASTROINTESTINAL UPSET, HEADACHE, MUSCLE PAIN OR FATIGUE?	_____ Yes _____ No
HAVE YOU EXPERIENCED RECENT LOSS OF TASTE OR SMELL?	_____ Yes _____ No
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED TO ANY REGIONS AFFECTED BY COVID-19 (AS RELEVANT TO YOUR LOCATION)?	_____ Yes _____ No
DO YOU HAVE HEART DISEASE, LUNG DISEASE, KIDNEY DISEASE, OR ANY AUTOIMMUNE DISORDERS?	_____ Yes _____ No
HAVE YOU BEEN IN CONTACT WITH ANY CONFIRMED COVID-19 POSITIVE PATIENTS?	_____ Yes _____ No
ARE YOU OVER THE AGE OF 60?	_____ Yes _____ No
HAVE YOU BEEN TESTED FOR COVID 19 IN THE LAST 10 DAYS?	_____ Yes _____ No

If YES to any of the above, please explain:

_____
_____
_____
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