COVID 19 SCREENING QUESTIONNAIRE

To help ensure everyone's safety, you must complete this form prior to your appointment, and pass the screening before being admitted to the clinic. Please bring this form with you. You must call or email the office before your appointment to discuss your situation if you answer "Disagree" to any question." Future screenings will be done by phone prior to your appointment.

1) Currently, and within the last 30 days, I HAVE NOT HAD CONTACT WITH, NOR PROVIDED CARE FOR, ANY PERSON WHO WAS INFECTED WITH, TESTED POSITIVE FOR, OR WHOM WAS A SUSPECTED CASE OF COVID 19.

Agree _____ Disagree _____

2) Currently, and within the last 30 days, I have NOT been diagnosed with COVID 19, felt sick or ill, or had symptoms such as FEVER, HEADACHE, DRY COUGH, SHORTNESS OF BREATH, RUNNY NOSE, SORE THROAT, LOSS OF TASTE /SMELL, BODY ACHES, or DIARRHEA

Agree _____ Disagree _____

3) Because travel or being in a large crowd increases risk, I verify I have NOT TRAVELED (OR BEEN IN A LARGE GATHERING) in the last 14 days either: Internationally, outside the United States, or domestically within the United States by commercial airline, cruise ship, bus, or train, nor have I been exposed to a large crowd such as at the beach, amusement park, protest/rally, sports event etc.

Agree _____ Disagree _____

4) I AGREE I WILL CONTACT THIS OFFICE IMMEDIATELY if within a two-week period of my visit I develop any symptoms of, or suspect I have contracted COVID 19, or receive a positive test result. (Your identity will be kept confidential)

CONSENT FOR TREATMENT DURING COVID 19

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization, and that it is extremely contagious. I understand determining who is infected with COVID-19 is exceptionally difficult because carriers of the virus may be asymptomatic. This information is being provided to assist me in making informed choices, which involves my understanding and consent regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. To proceed with care, you must read and initial the following, and sign & date at the bottom.

• I acknowledge that I am opting for an elective treatment at my own risk. I understand that I have the option to defer treatment to a later date, and was advised to postpone preventative or wellness treatments, and only seek treatment if my symptoms are of an urgent, debilitating, or painful nature that significantly impacts my quality of life. I understand the potential risks with receiving treatment during the COVID 19 pandemic, and agree to proceed with my desired treatment at this time.

Initial here_____

• I understand that my practitioner is implementing measures to minimize the spread of COVID 19. However, given the nature of the virus and the health care setting, and the close physical nature of practicing acupuncture, I understand that it may put me at an increased risk of contracting COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of this possibility, and give my express permission to proceed.

Initial here_____

• Furthermore, in assuming this risk, it means I agree not to hold my practitioner or Confluence Healing Acupuncture liable in any way, whether this is through accident, or any other means or fault of this facility, nor will I seek any legal action for damages or financial losses, or for any other potential consequences including, but not limited to, major health complications, should I contract COVID 19 from visiting this office now, or upon any subsequent visit in the future. I understand that these potential consequences may also extend to my family, or any others I have contact with.

Initial here_____

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE READ AND AGREED TO ALL OF THE ABOVE PROVISIONS, AND CONSENT TO TREATMENT, AND THAT I HAVE HAD ALL OF MY QUESTIONS ANSWERED TO MY SATISFACTION, AND THAT I FULLY UNDERSTAND THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID 19 PANDEMIC.

Patient Name (print):_____ Date:_____

Patient Signature (or Parent if minor) _____

Practitioner Signature _____ Date:_____