ACKNOWLEDGEMENT OF PATIENT RESPONSIBILITIES FOR IN-OFFICE PROCEDURES AND TESTING DURING COVID-19

COVID-19 presents special challenges to you and your medical team for your procedure or test.

1. I understand that I (and my personal caregiver, if applicable) will be screened by telephone for symptoms and previous exposure.
2. I understand that I may need to be tested for SARS-CoV-2 (COVID-19) within a few days of my procedure. If the test is positive, my procedure may be postponed to a later date.
3. Should I need to get tested, I agree to self-isolate after the test until the time of my procedure to avoid potential infection.
4. I understand that I will be required to wear a mask when entering and while inside the facility. If I do not have a mask, one will be provided to me.
5. I understand that upon arrival to the facility, I will be screened for COVID-19 symptoms and have my temperature checked.
6. I understand that if I require a caregiver, parent, or guardian to accompany me, they will also be required to comply with infection control measures (e.g. wearing a mask and symptom screening when entering the clinic or hospital).
7. I will engage in social distancing both before my procedure / test and for up to 14 days after my procedure/ test if instructed to do so. I will immediately contact my provider if I develop any of the following symptoms before or after my procedure/test: cough, shortness of breath, fever, chills, muscle aches, headaches, sore throat, or new loss or change of taste and/or sense of smell.

By signing below, I agree to follow all the requirements outlined above. I understand that failure to follow the requirements above may result in my procedure / test being postponed.

______________________________ ______________

PATIENT/LEGAL REPRESENTATIVE SIGNATURE DATE

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PRINTED NAME Relationship to patient

PATIENT IDENTIFICATION