COVID-19 Office Policy

Name:_____ DATE:_____

I understand that during my office visit

1.I will participate in social distancing as feasible

2.I will wear a mask during my visit

3.I understand that I will be the only patient in the office at any given time during my visit

4.I will not enter this office for treatment if I have a fever, sore throat, cough, shortness of breath or any other respiratory symptoms or diarrhea or history of vomiting.

5. I will not enter this office for treatment if during the past 14 days I have been exposed to any person with known or suspected COVID-19 infection

6.I understand the policy of this office is that no office staff member will be allowed to work and is required to stay home if they have similar symptoms as mentioned above as well as any exposure to COVID-19 as mentioned above

7.The office staff will wear masks, gloves and PPE as needed, participate in frequent hand washing as frequently as needed. Gloves will be changed by personnel between each patient.

Patient Signature:_____