***LEGAL NOTICE/DISCLAIMER***

***The information contained in this document does not establish a standard of care, nor does it constitute legal advice and has been developed in response to the needs of our insureds. The information is for general informational purposes only and is written from a risk management perspective to help aid in reducing professional liability exposure. Please review this document for applicability to your specific practice. You are encouraged to consult with your personal attorney for legal advice, as specific legal requirements may vary from state to state.***

**Note: This authorization is to be reviewed with the patient and signed by the patient PRIOR to medical encounter/telehealth visit. Please check CMS, Federal and your State regulations related to telehealth services.**

**<<Practice Name>>**

**SAMPLE Patient Acknowledgement to Receive Treatment during COVID-19**

The CDC recommends postponing all nonessential or elective healthcare visits and group-related activities, and states are mandating the provision of emergency services only.

* While our office complies with Federal, 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 about your health and safety.
* I hereby acknowledge and understand that there may be an increased risk that COVID-19 may be transmitted in any place of public accommodation, which includes my physician’s office. I have been informed by my physician of their desire to protect their patients, staff and the community at large.

To the best of our knowledge, <<PRACTICE NAME>> staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of healthcare services, other persons (including other patients) could be infected, with or without their knowledge.

As a prerequisite to receiving care/treatment, we are asking out patients and their accompanying party(s) to complete the screening attestation form below.

**Attestation:** Circle if you are: **Patient or Accompanying Party**

***Each complete their own Attestation***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **In the last 48 hours have you experienced:** | | | Yes | No |
|  | Fever | |  |  |
|  | Any shortness of breath | |  |  |
|  | Dry cough | |  |  |
|  | Runny nose | |  |  |
|  | Sore throat | |  |  |
|  | Los of taste and/or smell sensation | |  |  |
| **WITHIN THE LAST 14 DAYS have you:** | | |  |  |
|  | Travelled to a foreign country | |  |  |
|  | Have you travelled within the US via: | |  |  |
|  |  | Airplane |  |  |
|  |  | Cruise ship |  |  |
|  |  | Train |  |  |
|  |  | Public transportation |  |  |
|  |  |  |  |  |

If yes, to any of the above questions, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have been practicing all current CDC guidelines with respect to “social distancing” and have NOT been in contact with a person who had a positive test for COVID-19 or suspected to be positive.

**Accompanying Accompanying**

**Party name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Party signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have been practicing all current CDC guidelines with respect to “social distancing” and have NOT been in contact with a person who had a positive test for COVID-19 or suspected to be positive.

I hereby consent to the treatment proposed by my physician.

**Patient’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_