MERIDIAN
PSYCHIATRIC PARTNERS

ADVISORY & ACKNOWLEDGEMENT AGREEMENT

RECEIVING MEDICAL TREATMENT DURING THE COVID-19 PANDEMIC

You have come to our office today for a routine medical evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

- While our office complies with 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.
- Our 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 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.

PATIENT/RESPONSIBLE PARTY ____________________ DATE ____________

☐ **I HAVE BEEN VACCINATED.** Dose 1 Date: ____________ Dose 2 Date: ____________

PLEASE CHECK “YES” OR “NO” FOR THE FOLLOWING QUESTIONS:

1. HAVE YOU BEEN DIAGNOSED POSITIVE FOR THE COVID-19 VIRUS AT ANY TIME? ☐ YES ☐ NO
2. ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST? ☐ YES ☐ NO
3. HAVE YOU BEEN EXPOSED TO ANYONE WHO HAS BEEN DIAGNOSED WITH COVID-19 IN THE PAST 21 DAYS? ☐ YES ☐ NO
4. DO YOU HAVE A FEVER? ☐ YES ☐ NO
5. DO YOU HAVE ANY SHORTNESS OF BREATH? ☐ YES ☐ NO
6. DO YOU HAVE A DRY COUGH? ☐ YES ☐ NO
7. DO YOU HAVE A RUNNY NOSE? ☐ YES ☐ NO
8. DO YOU HAVE A SORE THROAT? ☐ YES ☐ NO
9. DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES? ☐ YES ☐ NO
10. HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS? ☐ YES ☐ NO
11. HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL? ☐ YES ☐ NO

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