Neurology & Sleep Associates

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COVID-19 PATIENT TREATMENT AND CONSENT

I, ____, knowingly and willingly consent to in-office medical treatment during the COVID-19 pandemic at Neurology Sleep and Pulmonary Specialists..

I understand due to other patients seen in-office, I may have an elevated risk of contracting the virus by having an in-office visit.

I confirm I am not presenting any of the following symptoms of COVID-19:

- Fever with or without chills
- Shortness of Breath, difficulty breathing
- Dry Cough; coughing up sputum (mucus, phlegm)
- Significant fatigue
- Runny or Stuffy Nose
- Sore Throat
- Loss of smell or taste

I understand the CDC recommends social distancing of at least six (6) feet which may not be possible at all times while in the office. I hereby agree to wear a mask at all times while in the offices of Neurology Sleep and Pulmonary Specialists.

I verify I have not been in contact with any persons who have shown symptoms or have been diagnosed with COVID-19 for the past 14 days.

I verify I have not traveled outside of the United States in the past 14 days.

I verify I have not traveled domestically within the United States by commercial airline, bus or train within the past 14 days.

I understand if I begin to show symptoms or test positive for COVID-19 within 14 days following my appointment, I will notify Neurology Sleep and Pulmonary Specialists.

Signature: ____ Date: _____________________

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