PROMEDMA Clinic

Coronavirus Liability Release Form

For the safety and peace of mind of both patient and practitioner, additional precautions are being taken due to the COVID-19 virus. In addition to increasing our usual sanitation and disinfecting practices, we now require patients to complete a digital screening and liability form prior to their appointment.

Treatment will not be provided to anyone with COVID-19, or who shows any symptoms of cough, flu, cold, or any type of respiratory or bacterial infection. Further, if you are taking antibiotics, you will be expected to post pone treatment even if you no longer have any symptoms.

You **must** complete and submit the following form prior to your visit in order to receive treatment:

I understand the above terms and agree to the following: (please initial beside each statement below)

1. No one in my household, including myself, has (or has come into contact with anyone who has) experienced the following symptoms in the past 14 days: fever/feeling feverish, runny nose, sore throat, nasal congestion, excessive fatigue, new or existing cough, cold or flu-like symptoms and/or difficulty breathing.

   Agree ○ **Disagree** ○
2. No one in my household, including myself, has travelled outside of the city, state/province or country within the last 14 days.

   Agree ○ **Disagree** ○
3. No one in my household, including myself, has come into contact with anyone who has travelled outside of the city, state/province or country within the last 14 days.

   Agree ○ **Disagree** ○
4. No one in my household, including myself, has been tested for or diagnosed with COVID-19 in the last 14 days.

   Agree ○ **Disagree** ○
5. No one in my household, including myself, has come into contact with or cared for a confirmed or probable COVID-19 case.

   Agree ○ **Disagree** ○
6. I am not currently taking any antibiotics.

   Agree ○ **Disagree** ○
7. If at anytime before my appointment I or anyone in my household experience:
   - Fever
   - Fatigue

- Dry cough
- Difficulty breathing
- Runny nose
- Sore throat
- Nasal congestion
- Aches and pains
- Any other COLD or FLU type symptoms

OR come into contact with or care for anyone experiencing the above symptoms
OR come into contact with or care for confirmed or probable case of COVID-19
OR come into contact with or care for anyone who out of the city in the past 14 days

I understand that I will be expected, for the protection of myself and my community, to call the clinic and reschedule my appointment. I understand that **PROMEDMA Clinic** reserves the right, for the protection of myself and my community, to deny service to any person showing new or existing symptoms of COVID-19 or other any other contagion or respiratory illness at this time.

Agree ○ **Disagree** ○

By signing below, I certify that the above information is correct to the best of my knowledge, confirm that I have read and understood all of the terms and agreements provided in this form, and release **PROMEDMA Clinic** and their practitioner(s) and staff from any liability for exposure to COVID-19 or other contagions due to patient failure to adhere to the above terms of service, asymptomatic patients, or patients providing misinformation on this screening form. I promise and agree to **call the clinic** (not come in!) if I need to reschedule my appointment for any of the above reasons.

Patient Name:

Patient Signature: Date: