Serenity Wellness Clinic, LLC
8555 SW Tualatin Road, Suite B
Tualatin, Oregon, US - 97062

COVID-19 Advisory and Consent Form (Rev0121)

Receiving Medical Treatment During the COVID-19 Pandemic

I ask that you complete this form within 24 hours of any in person appointments. Each time you receive this questionnaire, please review your answers to the questions, update the date and submit again. If you have not completed this form prior to your appointment, you will be asked to complete it in the office.

Dear Patient:

You are scheduled for an in-person appointment for a routine medical evaluation and/or treatment that will be done during the COVID-19 pandemic.

While my offices (including other providers working for other organizations) comply 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 of safety. All providers and staff working in the physical office spaces in which I operate are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since these spaces are places 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 other patients, providers and staff as well as yourself, please be truthful and candid in your answers.

Please answer Yes or No to the following questions.

Are you currently awaiting the results of a COVID-19 test? *	☐ Yes ☐ No
Do you have a fever? *	☐ Yes ☐ No
Do you have shortness of breath? *	☐ Yes ☐ No
Do you have a cough? *	☐ Yes ☐ No
Do you have a runny nose? *	☐ Yes ☐ No
Do you have a sore throat? *	☐ Yes ☐ No
Do you have sneezing, water eyes, and/or sinus pain/pressure that is unusual and not related to seasonal allergies? *	☐ Yes ☐ No
Have you recently experienced new headaches, fatigue or weakness? *	☐ Yes ☐ No

Have you recently lost your sense of taste and/or smell? * ☐ Yes ☐ No

In the last 14 days, have you gathered in close proximity without masks with people outside of your immediate household? * ☐ Yes ☐ No

Within the last 14 days, have you traveled outside of Oregon? * ☐ Yes ☐ No

If so, where have your traveled? _____

Have you had a known exposure to COVID in the past 14 days? * ☐ Yes ☐ No

Signature

My signature below indicates that I have answered the above questions honestly and to the best of my knowledge. My signature also indicates my acknowledgement that the offices of Dr. Bijana Kadakia and Serenity Wellness Clinic, LLC are places of public accommodation and that while infection control procedures are in place, risk cannot be completely eliminated and I accept the risk of appearing for an in-person appointment. I am aware the telemedicine visits are available as an alternative to in-person appointments.

PATIENT SIGNATURE * _____

DATE * _____