serenity
WELLNESS CLINIC
BIJANA KADAKIA ND LAC

COVID-19 Advisory and Consent Form

(Rev 0121)

Receiving Medical Treatment During the COVID-19 Pandemic

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. We will ask that you complete this form within 24 hours of any in person appointments. 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 your safety and that of other patients, providers, 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
Have you had a known exposure to COVID-19 in the past 14 days?	Yes	No
Do you have a fever?	Yes	No
Do you have any 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, watery eyes or sinus pain/pressure?	Yes	No
Have you recently experienced new headache, fatigue or weakness?	Yes	No
Have you recently lost your sense of taste 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 you traveled? _____

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 Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Tualatin Clinic address:
8555 SW Tualatin Road Suite B
Tualatin, OR 97062
Phone:503-987-3622

Scappoose Clinic address:
51669 SW Columbia River Hwy Suite 130
Scappoose, OR 97056
DoctorBijana.com

Business Mailing address:
PO Box 230095
Tigard, OR 97281
Fax:503-987-3022