serenity
WELLNESS CLINIC
BIJANA KADAKIA ND LAC

COVID-19 Advisory and Consent Form

(Rev 051622)

Receiving Medical Treatment During the COVID-19 Pandemic

You are scheduled for an in-person appointment for a medical visit or acupuncture treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

- While my 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, I cannot make any guarantees of safety.
- Because my office is a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge and pose a risk to you.

In order to reduce the risk of spreading COVID-19, masks remain a requirement in my office and I am asking you a number of screening questions below. For the safety of providers, other patients, and yourself, please be truthful and candid in your answers.

Please answer YES or NO to the following questions

Have you had a known exposure to COVID-19 in the past 10 days? Yes No

Are you currently awaiting the results of a COVID-19 test? Yes No

Do you currently have any of the following symptoms: Yes No

- fever
- shortness of breath
- cough
- runny nose
- sore throat
- change in sense of taste or smell
- new headache
- fatigue or weakness

Vaccination

Have you been vaccinated against COVID-19? Yes No

If so, what brand(s) of vaccine did you receive and approximately when was your last dose:

_____

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 that telemedicine visits are available as an alternative to in-person appointments.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

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