WESTCHESTER CENTER FOR DERMATOLOGY

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Please answer the following prior to your appointment.

Have you traveled on a plane within the past 14 days? Yes_ No_.

Have you had close contact with a person with Coronavirus (COVID_19), or any other known infectious disease? Yes_ No_.

Do you have a temperature of 100.4 {36C} or feel hot? Yes_ No_.

Do you have shortness of breath, sore throat? Yes_ No_.

Are you vomiting or have diarrhea? Yes_ No_.

Do you have any rash? Yes_ No_.

Do you practice social distancing? Yes_ No_.

In the last two weeks, have you been in any of the following states: Yes_ No_.

Alabama, Arkansas, Arizona, California, Delaware, Florida, Georgia, Iowa, Idaho, Kansas, Louisiana, Mississippi, North Carolina, Nevada, Oklahoma, South Carolina, Tennessee, Texas, Utah

Please be advised that your upcoming patient visit with one of our practitioners comes during a time of unknown risks of transmission due to the Corona virus (COVID-19). We will be taking all possible precautionary measures in our office to prevent transmission including but not limited to; the use of facial masks and gloves, sanitizing exam rooms and equipment, and providing available restrooms for necessary hand washing. While we do our necessary part in reducing the chances of transmission it is not guaranteed that the virus cannot be spread from person to person. This letter is to notify you that your decision to see a practitioner at our facility may possibly come with unknown risks of transmission of COVID-19 and thus you are making the decision at your own risk and free will to attend your doctor visit today. By signing below, you release the practitioners and our office from any and all liability associated with possible transmission of the COVID-19 virus and the possibility that you may become infected. In addition to reduce this risk you have the option to be seen later per your discretion.

Patient Name:_______________________________________

Patient Signature:___________________________________

Date:_________________