Patient Name: _____ Date:_____

Please note that for the safety of our staff and other patients, ***all persons at HLPTS INC must wear a face mask.*** Due to a worldwide shortage of medical masks, we ask that patients bring their own from home. Homemade masks are acceptable.

Please answer the following questions. Check all boxes that apply:

☐ Exposure to person with a lab-confirmed case of COVID-19 within the past 14 days

In the last 48 hours, have you experienced:

☐ Fever over 100.5°F/38°C

☐ New cough, shortness of breath, or difficulty breathing

☐ New loss of sense of smell or change in taste

If you check any of the boxes above, unfortunately we cannot treat you at this time. We will be happy to offer a telehealth consult or refer you to an appropriate facility.

In the last 48 hours, have you experienced:

☐ New changes in skin (rash, skin discoloration, discoloration of toes)

☐ New chills, feeling cold, or shivering

☐ New headache

☐ New fatigue

☐ Sore throat

☐ Nausea/vomiting

☐ Diarrhea

☐ New nasal congestion or runny nose

☐ New body or muscle aches

If you check three (3) or more boxes above, unfortunately we cannot treat you at this time. We will be happy to offer a telehealth consult or refer you to an appropriate facility.

I acknowledge that the information provided above is correct:

Signed: _____ Date:_____

While on the premises of HLPTS INC, I agree to:

Please Initial:

_____ I will maintain a distance of six (6) feet from other persons whenever possible.

_____ I will wear a face mask at my clinic visit, and will not remove the mask except when directed.

_____ I will wash my hands for 20 seconds before and after my treatment, and before and after using the restroom.

_____ I will practice proper cough & sneeze etiquette by coughing/sneezing into my elbow, and to give warning to others if I am about to cough or sneeze, so that they can maintain a safe distance.

_____ I will remain outside the clinic or in my car until receiving a phone call to enter the clinic building.

_____ I will immediately notify HLPTS INC, [503-984-7198 if I develop symptoms of COVID-19 within fourteen (14) days of my clinic visit.

_____ I will be notified if my practitioner or any staff present at my visit develop symptoms of COVID-19 within fourteen days of my clinic visit.