Foot & Ankle Specialists of Mid-Michigan, PC
Patient Acknowledgement to Receive Treatment during COVID-19

The CDC recommends postponing all nonessential or elective healthcare visits and group-related activities, and states are mandating the provision of emergency services only.

- While our office complies with Federal, 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 about your health and safety.
- I hereby acknowledge and understand that there may be an increased risk that COVID-19 may be transmitted in any place of public accommodation, which includes my physician's office and the Operating room at Mid-Michigan Health and Great Lakes Bay Surgery Center. I have been informed by my physician of their desire to protect their patients, staff and the community at large.
- I acknowledge and understand that there may be an increased risk that COVID-19 may be transmitted during my procedure. I acknowledge and understand that no preoperative testing is taking place at site of surgery and therefore I may be at increased risk for accidental transmission. I acknowledge this is out of my physicians' control and I am requesting that my procedure be performed during this time.

To the best of our knowledge, Foot & Ankle Specialists of Mid-Michigan, PC staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of healthcare services, other persons (including other patients) could be infected, with or without their knowledge.

Patient's name: _____ **Patient's signature: _____**

Date: _____

Physician's name: _____ **Physician's signature: _____**

Date: _____

Date Implemented: _____
Date Reviewed: _____

As a prerequisite to receiving care/treatment, we are asking out patients and their accompanying party(s) to complete the screening attestation form below.

Attestation: Circle if you are: **Patient**

In the last 48 hours have you experienced:	Yes	No
Fever	☐	☐
Any shortness of breath	☐	☐
Dry cough	☐	☐
Runny nose	☐	☐
Sore throat	☐	☐
Loss of taste and/or smell sensation	☐	☐
WITHIN THE LAST 14 DAYS have you:		
Travelled to a foreign country	☐	☐
Have you travelled within the US via:		
Airplane	☐	☐
Cruise ship	☐	☐
Train	☐	☐
Public transportation	☐	☐
Been diagnosed with COVID19		

If yes, to any of the above questions, please explain: _____

_____

I have been practicing all current CDC guidelines with respect to "social distancing" and have NOT been in contact with a person who had a positive test for COVID-19 or suspected to be positive.

Accompanying Party name: _____

Accompanying Party signature: _____

Date: _____

I have been practicing all current CDC guidelines with respect to "social distancing" and have NOT been in contact with a person who had a positive test for COVID-19 or suspected to be positive.

I hereby consent to the treatment proposed by my physician.

Patient's name: _____

Patient's signature: _____

Date: _____

Physician's name: _____

Physician's signature: _____

Date: _____

Date Implemented: _____
Date Reviewed: _____