GBMC Health Partners COVID-19 Patient Consent

GBMC Health Partners values your safety and has been working hard to ensure that the hospital and physicians' practices are ready for you. Some of the measures GBMC Health Partners is taking to protect patients include: cleaning/disinfection of all workspaces, daily temperature screenings for patients and staff, and COVID-19 screening questions for patients.

I understand that, as COVID-19 is a community acquired disease, I could contract it anywhere, anytime, in the community. Based on consultation with my provider, I understand that I could meet my health care provider using telehealth, or in person. If indicated, I have decided to have an in-person visit with my health care provider. I understand that by coming to an in-person visit with my provider, I assume risks of exposure to COVID-19 and other public health risks that are known and unknown.

To have an in-person visit to a Health Partners' practice, I agree to take certain precautions and follow the guidelines of the Health Partners practices to keep myself and others safer. I agree that:

- I will keep my appointment only if I am feeling well and have no symptoms suggestive of COVID-19, including fever, cough, GI disturbance or loss of taste or smell. If I have any of these symptoms, my provider will determine if my visit will be in person or via telehealth.
- I will wear a face mask covering my mouth and nose and follow instructions of the GBMC Health Partners' staff regarding waiting location, safe distancing precautions and hand hygiene.
- I will inform the Health Partners practice staff if in the last 14 days, I have been in the company of anyone who has tested positive for COVID-19, or if a resident of my home or a family member tests positive for COVID-19, or if I have tested positive for COVID-19.
- I will not bring any companions to my appointment with me, unless it is medically necessary.

If you have tested positive for COVID-19, we must notify the local health department that you have been to the office. We must report the minimum necessary information for their data collection.

By signing this form, I agree to the above terms.

X_____ _____ _____
(Signature) (Date) (Time)

_____
(Print Name)

X_____ _____ _____ _____
(Authorized Health Care Decision Maker/ Authorized Patient Representative Signature) (Relationship to Patient) (Date) (Time)

* C O N S E N T *