GABRIELLE CZAJA, PT INC.

COVID-19 HEALTH SCREENING FORM

Have you been diagnosed with, tested for, or think that you have had COVID-19? Yes__No__

If yes, how were you confirmed?

When was your test?

Have you had an antibody test?

When were you confirmed negative?

Have you traveled outside of Washington DC (including MD and VA) in the past 14 days? Yes__No__

If yes, where, and how did you travel? I.e. car, train, plane

Have you been in groups of more than 10 people in the last 14 days? Yes__No__

Did you wear a mask the entire time? Yes__No__

Did you maintain stay 6' apart from other people? Yes__No__

Have you experienced in the past 21 days, or are you currently experiencing any of the following as a *new* pattern? Please circle:

Headache Fever Chills Cough Sore throat Diarrhea/Digestive Upset

Nasal/Sinus Congestion Loss of sense of taste or smell Fatigue

Shortness of breath, difficulty breathing, chest tightness

Sudden onset muscle soreness, not related to a specific activity

Rash or skin lesions (especially on the feet) Other flu-like symptoms

Is there anything else that concerns you?

By signing below, I affirm that the above answers are correct and true to the best of my knowledge. I understand that I may be asked to reschedule my appointment, at the discretion of my therapist, based upon my answers and discussion with her. I also understand that I will immediately notify the office, in writing, if any symptoms as above or in addition to the above, should change. In addition, I also understand that after my initial in-person office visit, at which time this form is signed, a verbal screen will be conducted at each subsequent visit. My signature also confirms that my verbal answers will be true to the best of my knowledge.

Name (printed) _____

Signature_____Date_____.

GABRIELLE CZAJA, PT INC.

HEALTH AND SAFETY PRECAUTIONS CONSENT FORM

In order to maintain the health and safety of myself, my therapist and the community, I agree to the following parameters, and understand the policies of this office when I attend appointments at the office of Gabrielle Czaja, PT Inc.

Appointments: Will be spaced such that there is ample time for cleaning in between each visit and to ensure that you are the only person in the office.

General health screening: A health questionnaire will be completed and signed prior to my first in-person appointment. A verbal screen will be conducted at the beginning of subsequent appointments. I understand that my temperature will be taken with a no-touch infrared thermometer immediately upon entering the suite, and recorded in my medical files.

Masks: Will be worn by me and by Gabrielle Czaja. If I arrive without one, I will be given the opportunity to purchase a cloth mask for $7. I understand that treatment will not be received if I do not wear a mask.

Hand washing: Upon entering the suite, I will immediately wash my hands before my session and immediately after my session, prior to departure. I will use warm water, lather up and scrub my hands and forearms for 20 seconds, and use paper towel to dry my hands.

Respiratory Etiquette: If I sneeze, I will do so into my shoulder/elbow or use a facial tissue. I will do my best to not touch my mask or face. If I inadvertently do, I will use either the hand sanitizer in the room or wash my hands with soap and water.

Sanitation: All contact surfaces will be sanitized with CDC compliant products, such as doorknobs, table and chairs and that the bathroom will be cleaned after each use.

Air Circulation: Weather permitting, and based on preferences, the windows in the studio will be slightly opened. The door to the studio will be left slightly open.

Payment: An insurance receipt will be sent via email or USPS. For checks, please write prior to coming to the office. If paying by credit card, I will not be touching the key pad or giving my card to Gabrielle. The information will be entered manually.

By signing below: I affirm and consent to following the above guidelines. I also understand that close contact with people at this time may increase the risk of infection from COVID-19. I acknowledge that I am aware of this risk and give consent to treatment.

Name (printed) _____

Signature_____Date_____.