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PATIENT ACKNOWLEDGMENT OF, ACCEPTANCE OF, AND INFORMED CONSENT TO POSSIBLE RISKS OF IN-PERSON TREATMENT AND INFECTIOUS DISEASES / CONDITIONS

I _____ (Patient Name) have elected to pursue in-person psychiatric treatment from Dr. Gulwadi at the office of Ashwini Gulwadi, PLLC.

By signing this, I attest that:
1. I am fully vaccinated against COVID-19 according to the CDC (i.e. it has been more than 2 weeks since I received the booster dose and either the second dose in a 2-dose series vaccine or a single-dose vaccine)
2. I will only attend my in-person appointment if I have no symptoms of COVID-19. If I should develop symptoms consistent with COVID-19 or flu prior to my appointment, I will not go into the office and will make arrangements with Dr. Gulwadi's office to transfer the appointment to a virtual visit.
4. I am aware of the symptoms consistent with COVID-19 or flu. It can be ONE or more of the following symptoms: (i) a fever (higher than 100.4 F) or chills, (ii) cough, (iii) shortness of breath or difficulty breathing, (iv) fatigue, (v) muscle or body aches, (vi) headache, (vii) new loss of tase or smell, (viii) sore throat, (ix) congestion or runny nose, (x) nausea or vomiting, (xi) diarrhea. I will keep track of the above-mentioned symptoms and will change to virtual visit if I have any of the above symptoms in the 10 days prior to the appointment.
4. I will immediately notify the office if I am diagnosed with Covid-19 after my in-person treatment.
5. If I am in isolation or quarantine due to testing positive for COVID-19 or exposure to COVID-19 or If I have knowingly had close contact with anyone infected with COVID-19 in the 10 days prior to an in-person appointment, then I will make arrangements with Dr. Gulwadi for virtual treatment during any time period.

I acknowledge that there may still be health risks involved in visiting the office and having face-to-face contact with Dr. Gulwadi. I understand and voluntarily accept those risks and have elected to receive my psychiatric care in person. I hereby release and waive any right to bring suit or otherwise make any claim against Dr. Gulwadi and/ or the office of Ashwini Gulwadi, PLLC in connection with exposure, infection and/or spread of COVID-19 or other infectious diseases/ conditions related to my in-person treatment.

I further acknowledge that if there is resurgence of the virus or if other health concerns arise, including a period of isolation/quarantine for Dr. Gulwadi, she may choose to return my visits to a virtual format. In such event, Dr. Gulwadi and I will discuss the reasons for this and make arrangements for continuing care virtually. I understand that I may elect to return to telehealth visits at any time.

If I am diagnosed with COVID-19, I understand and give my consent for Dr. Gulwadi to comply with all required notifications to health authorities by providing the minimum necessary information for their data collection. By signing this form, I agree to this without the necessity of any additional release.

This PATIENT ACKNOWLEDGEMENT OF, ACCEPTENCE OF AND INFORMED CONSENT TO POSSIBLE RISKS OF IN-PERSON TREATMENT supplements the general informed consent and other business agreements I have agreed to with Dr. Gulwadi during our work together.

Acknowledge, Accepted and Agreed on date_____ BY:

_____
Patient Signature

_____
Printed Patient Name