Ascension Physical Therapy Infection Control Policy

Our staff remains committed to ensuring the health and safety of everyone who walks through our doors. We are continuing to practice a high level of infection control and follow all guidelines from the Centers for Disease Control and Prevention to limit the exposure of any virus within our office. Please help us by participating in the following precautions:

- If you have any symptoms of illness please call and reschedule your appointment
- All patients and visitors will be required to wear a mask or facial covering to enter our facilities and while they are in the clinic. Masks or facial coverings are provided if you do not have one.
- We ask that you please wash your hands with soap and water or disinfect with hand sanitizer upon arrival.
- We will be practicing social distancing measures in our office as we are able, such as limiting handshakes and limiting the number of people in the waiting room.

COVID-19 SCREENING QUESTIONS

1. **Have you been confirmed positive for COVID-19?________**
2. **Are you currently experiencing, or have you recently experienced any symptoms such as fever, cough, shortness of breath, fatigue, muscle or body aches, headache, new loss of taste or smell, congestion or runny nose, nausea or diarrhea?__________**
3. **Have you knowingly been in close contact with anyone who has been confirmed positive for COVID-19?__________**
4. **Have you traveled out of state within the last 10 days?_______**

- If any of your answers to the COVID screening questions change at any time during your time as a patient at Ascension Physical Therapy please notify us immediately.
- If any of your answers to the COVID screening questions change within 48 hours of your PT visit please notify us immediately.

By signing this form, I have read and understand the information provided regarding infection control policies and COVID-19 screening and agree to comply with the above statements.
I understand that Ascension Physical Therapy has the right to reschedule my appointment if I answered yes to any of the questions on this form.

Signature of Patient (or person authorized to sign for patient):

__________________________________ Date: _____________