PART I
PATIENT SCREENING QUESTIONNAIRE FOR RECEIVING DENTAL TREATMENT DURING THE COVID-19 PANDEMIC AND HIPAA - RISKS & INFORMED CONSENT

Dear Patient:

You have come to our office today for treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

Our staff are symptom-free and, to the best of our knowledge, have been practicing recommended guidelines. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

PLEASE ANSWER "YES" OR "NO" TO THE FOLLOWING QUESTIONS:

Have you been diagnosed positive for the COVID-19 virus at any time?______________ ☐Yes ☐ No
Are you currently awaiting the results of a COVID-19 test? ________________________ ☐Yes ☐ No
Within the past 14 days:

1. have you had a fever? ____ ☐Yes ☐ No
2. have you had any shortness of breath? ______________________________ ☐Yes ☐ No
3. have you had a dry cough? ____ ☐Yes ☐ No
4. have you had a runny nose?____ ☐Yes ☐ No
5. have you had a sore throat?____ ☐Yes ☐ No
6. have you had sneezing, watery eyes, and/or sinus pain/pressure?______________ ☐Yes ☐ No
   a. If, yes, is your sneezing, watery eyes, and/or sinus pain/pressure unusual or unrelated to seasonal allergies?______________________________ ☐Yes ☐ No
7. have you experienced headaches, fatigue, or weakness? ______________________ ☐Yes ☐ No
8. have you lost your sense of taste and/or smell? _____________________________ ☐Yes ☐ No
9. have you been in contact with anyone who has had any of the above symptoms or has been confirmed to be COVID-19–positive? ____________________________ ☐Yes ☐ No
10. have you been in public, within six feet of others (not from your household) without a face mask? ____ ☐Yes ☐ No
11. have you travelled within the united states or to any foreign country?____________ ☐Yes ☐ No
    a. if so, where & when____

12. Please complete, print, and sign this screening questionnaire.
13. This form must be electronically transmitted to us within **24 hours prior to your appointment** by either fax to (914) 723-1972, or by **email to** megtomeg@gmail.com.
14. Please read and complete Part II of this form, which explains the risks of using unencrypted email. Your failure electronically submit this form to us within 24 hours of your appointment, by either fax or email, will result in our not being able to accommodate you in person. This is for the safety of other patients and our staff. However, we may be able to see you through our Teledentistry service. To learn more about our Teledentistry services, please visit our website at www.roberthorowitzdds.com.

Dr. Robert A. Horowitz
2 Overhill Rd., Suite 270 • Scarsdale, NY 10583
phone: 914-723-3366 • facsimile: 914-723-1972

PART II
PATIENT SCREENING QUESTIONNAIRE FOR RECEIVING DENTAL TREATMENT DURING THE COVID-19 PANDEMIC AND HIPAA - RISKS & INFORMED CONSENT

- HIPAA stands for the *Health Insurance Portability and Accountability Act*
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information
- Information stored on our computers is encrypted
- Most popular email services (ex. Hotmail® and Yahoo®) do not utilize encrypted email. While Gmail does use encrypted email, it is only between two Gmail accounts, and our office does not use Gmail.
- **When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.**
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA
- The information is available in the Federal Register in pdf form (at page 5634) on the U.S. Department of Health and Human Services website - https://www.govinfo.gov/content/pkg/FR-2013-01-25/pdf/2013-01073.pdf. It may also be found in the FAQ.
- The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email

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I have truthfully completed Part I of this form. I understand that my failure to do may place other patients and the staff of Robert A. Horowitz, DDS at risk for contracting COVID-19.

I have read Part II, and have had the opportunity to have any questions answered that I may have. I understand the risks of using unencrypted email. I also understand that in order to have an in-person appointment accommodated, the office of Robert A. Horowitz, DDS requires me to complete and transmit the COVID-19 Screening Questionnaire 24 hours prior to my appointment.

Please check the appropriate box.

☐ I will email my completed form to the office of Robert A. Horowitz, DDS
☐ I will transmit the form via facsimile to 914-723-1972, because I do not wish to use email.

________________	____________	______________	________________
Patient's Signature (or Patient's Guardian)	Date	Printed name	Please print email address

If you are unable to print this form and email it, please copy and paste the questionnaire and HIPAA Email Consent into a composed email.

Dr. Robert A. Horowitz
2 Overhill Rd., Suite 270 • Scarsdale, NY 10583
phone: 914-723-3366 • facsimile: 914-723-1972