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INFORMED CONSENT AND WAIVER FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (my and yours together) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully as this document contains important information about your rights and safety. If you have any questions after reading this, I will be able to answer them. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face

We have agreed to meet in person for some or all future sessions. However, if there is a resurgence of the COVID-19 virus, or if other health concerns arise, I may require that we utilize Teletherapy to conduct our sessions. I will address any concerns that you may have about utilizing Teletherapy before implementing it with you. As your therapist, I reserve the right to return to Teletherapy as our primary modality of therapy if I determine, in my sole discretion, that it is in the best interest of everyone's well-being to do so.

If you decide at any time that you would feel safer staying with, or returning to, Teletherapy services, I will respect that decision, as long as it is feasible and clinically appropriate.

<u>You agree to wear the clear mask provided during the entire therapy session.</u>

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help minimize the risk of exposure, sickness and possible death for you, me, your family, and my other clients/patients If you do not adhere to these safeguards, it may result in our starting and/or returning to a telehealth arrangement. Initial each to indicate that you understand and agree to these actions:

- You will only keep your in-person appointment if you are symptom free and have been symptom free for fourteen (14) consecutive days. _____
- You will take your temperature before coming to each appointment. If it is elevated (100 degrees Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, I will not charge you my normal cancellation fee. _____
- You will wait in your car or outside the building - text me when you arrive and I will text you when I will meet you at the back door _____
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building. _____
- You will not wait in the waiting room. _____
- You will wear a mask in all areas of the office. _____
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me. _____
- You will take steps between appointments to minimize your exposure to COVID-19. _____

- If you have a job that exposes you to other people who are infected, you will notify myself immediately and we will conduct all sessions via Teletherapy. _____
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will notify me immediately. _____
- If a resident of your home tests positive for the infection, you will notify me and/or my staff immediately and we will begin or resume treatment via Teletherapy. _____
- If you experience any of the following symptoms, you will immediately notify me and/or my staff: fever of 100 degrees Fahrenheit or higher, shortness of breath, dry cough, sore throat, diminished sense of taste or smell. _____

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure

My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick

You understand that I am committed to keeping you, me, others in the building and all of our families safe from the spread of this virus. If you show up for an appointment and I believe that you have a fever or other symptoms, or believe you have been exposed, we will require you to leave the office immediately. We will follow up via Teletherapy if this occurs.

If I or anyone in my family test positive for the coronavirus, we will notify you immediately so that you can take appropriate precautions. Should this occur, we will immediately implement Teletherapy as the modality of therapy until we are symptom-free for fourteen (14) consecutive days.

Your Confidentiality in the Case of Infection

If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Risks of Opting for In-Person Services

You understand that by coming into the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). You further understand that there is a risk of contracting the virus simply by being in the office, even though standard precautions are being taken by myself and/or my staff. This risk may increase if you travel by public transportation, cab, or ridesharing service.

Informed Consent

My signature below indicates that I have been offered the option of Teletherapy, but I am choosing in-person, face-to-face sessions at my own discretion, not under force or duress from any other person. I further

understand that this agreement supplements my therapist's Disclosure Statement that we agreed to at the start of our work together.

I HAVE READ THE ABOVE WARNING, WAIVER, AND RELEASE AND UNDERSTAND THAT I GIVE UP SUBSTANTIAL RIGHTS FOR MYSELF AND/OR MY MINOR CHILD(REN) BY SIGNING IT, AND KNOWING THIS, SIGN IT VOLUNTARILY. I AGREE TO IN-PERSON, FACE-TO-FACE THERAPY APPOINTMENTS, KNOWING THE RISKS AND CONDITIONS INVOLVED AND DO SO ENTIRELY OF MY OWN FREE WILL. I UNDERSTAND THAT I AM WAIVING CERTAIN LEGAL RIGHTS THAT I OR MY MINOR CHILD(REN) MAY HAVE. I AFFIRM THAT I AM AT LEAST 18 YEARS OF AGE, OR, IF I AM UNDER 18 YEARS OF AGE, I HAVE OBTAINED THE REQUIRED CONSENT OF MY PARENTS/GUARDIAN AS EVIDENCED BY THEIR SIGNATURES BELOW.

Phone Number: ______________________________

____ ____________
Client Name/Signature DATE

____ ____________
Client Name/Signature DATE

____ ____________
THERAPIST NAME (Therapist) Signature DATE