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

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. 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. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone’s well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate.Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

**Risks of Opting for In-Person Services**

You understand that by coming to the office, you are assuming the risk of exposure to COVID-19 (or other public health risks). This risk may increase if you travel by public transportation, cab, or ridesharing service.

**Your Responsibility to Minimize Your Exposure**

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, our families, and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Please initial each of the following to indicate that you understand and agree to these actions:

* I will only keep your in-person appointment if I am free of flue/COVID-19 symptoms. \_\_\_
* If my temperature it is elevated (100 Fahrenheit or more), or if I have other symptoms of the flu/COVID-19, I agree to cancel the appointment or proceed using telehealth. \_\_
* I will adhere to the safe distancing precautions set up in the therapy room.\_\_\_
* During workshops with more than 1 participant in the office, we get to wear a mask. \_\_\_
* I will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with the therapist [or other workshop participants]. \_\_\_
* I will take steps between appointments to minimize my exposure to COVID. \_\_\_
* If I have a job that exposes me to other people who may be infected, I will immediately let my therapist know. \_\_\_
* If my commute or other responsibilities or activities put me in close contact with others (beyond my family), I will let the therapist know. \_\_\_
* If a resident of myr home tests positive for COVID-19, I will immediately let the therapist know and we will then begin/resume treatment via telehealth.\_\_\_

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, my staff and all of our families safe from the spread of this virus. If you show up for an appointment and I [or my office staff] believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I or my staff test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

**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.

**Informed Consent**

This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

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Patient/Client Date

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Psychologist Date