



## **INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 OR OTHER PUBLIC HEALTH CRISES**

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 or other public health crises. 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 or begin to utilize 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 the coronavirus (or other public health risk). 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, and our families, [our other staff] 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.

### ***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. \_\_\_
- You will take your temperature before coming to each appointment. If it is elevated (100 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 late cancel for this reason ONLY, we won't charge you our normal late cancellation fee. However, a late cancel due to symptoms will require that any future appointments must be by telehealth until either 14 days have passed, or you are able to produce a negative COVID-19 test. \_\_\_
- You will wait in your car or outside [or in a designated safer waiting area] until no earlier than 5 minutes before our appointment time. \_\_\_
- You will wash your hands or use your personal alcohol-based hand sanitizer when you enter the building. \_\_\_
- You may use a tissue provided or other non-direct hand contact method of your choice to flip up the light switch notifying your doctor you have arrived. \_\_\_
- You will adhere to the safe distancing precautions we have set up in the waiting room and therapy room. For example, you won't move chairs or furniture. \_\_\_
- It is voluntary for you and/or for your provider to wear a mask. \_\_\_
- If you choose to take off your mask at any time you understand your risk of exposure and will not hold SPW in any way responsible. \_\_\_
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me [or staff]. \_\_\_
- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands. \_\_\_
- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols. \_\_\_
- During the course of child/adolescent therapy board games are sometimes played and drawing materials are sometimes used. Your provider will do their best to disinfect materials between uses, but the materials may not be thoroughly sanitized. If you do not want your child using these shared materials please notify your

provider. Your provider will let you know if bringing your own materials from home is appropriate to your child's treatment plan. \_\_\_

- 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 immediately let me [and our staff] know. \_\_\_
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me [and our staff] know. \_\_\_
- If a resident of your home tests positive for the infection, you will immediately let me [and our staff] 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.

**Our Commitment to Minimize Exposure**

Our 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, [our staff] and all of our families safe from the spread of this virus. If you show up for an appointment and I [or our 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 our 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.

\_\_\_\_\_  
Patient/Legal Guardian Signature

\_\_\_\_\_  
Date