



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

*This document contains important information about our decision (yours and mine) to begin/resume in-person sessions in light of the COVID-19 public health crisis. My decision is based in part on recommendations by the Center for Disease Control (CDC), but other factors may be considered. Some of these include but are not limited to: whether we and our families have been vaccinated, our health or the health of those we are in close contact with, and risk of exposure outside of this setting. There may be other concerns that we can talk about.*

*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.

### **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, our families, and other clients) 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 and anyone else in your household needs to have been vaccinated.
- You will only keep your in-person appointment if you are symptom free.
- You will only keep your in-person appointment if you have been fever free for a minimum of 10 days prior to our appointment.
- You may choose to wear a mask in all areas of the suite, including inside the counseling room (if you so choose). At this time the wearing of a mask is voluntary.
- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols.
- You will take steps between appointments to minimize your exposure to COVID.
- If a resident of your home tests positive for the infection, you will immediately let me know and we will then switch to 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, as mentioned above in our facilities use guidelines. 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, myself, 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, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I 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 / therapeutic contract 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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*Client*

\_\_\_\_\_

*Date*

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*Client*

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*Date*

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*Client*

\_\_\_\_\_

*Date*

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*Myles Downes, LMFT*

\_\_\_\_\_

*Date*