Informed Consent for In-Person Clinical Social Work Services During Covid-19 Pandemic

I, _____, consent to participate in in-person psychotherapy sessions with _____ (my therapist) at their place of business.

1. I understand the following with respect to in-person sessions during the Covid-19 pandemic:
    a. I understand that Covid-19 is extremely contagious and is spread primarily by person-to-person contact.
    b. I understand that my therapist has adopted reasonable preventative measures intended to reduce the spread of Covid-19, but there is still a possibility of transmission as a result of attending in-person therapy.
    c. I understand that federal and state laws typically authorize public health departments to collect patient information to prevent or control disease and for related public health needs.
    d. I understand that my therapist may be required to report Covid-19 related patient information to public health departments, HHS, or the CDC. For example, if anyone who has been in my therapist's office tests positive for Covid-19, disclosure may be necessary for contact tracing or other data collection needs. If reporting is required, only the minimum necessary information will be disclosed.
2. I agree to the following with respect to in-person sessions during the Covid-19 pandemic:
    a. I will comply with safety precautions to limit the spread of Covid-19, as directed by my therapist.
    b. I will notify my therapist as soon as possible before my appointment if I have symptoms of Covid-19 or have been exposed to certain risk factors as directed by my therapist. If this happens, I will cancel my appointment unless my therapist directs me to come in.

I knowingly and willingly consent to have in-person sessions during the Covid-19 pandemic, and I acknowledge the health risk of Covid-19 during this pandemic. I have read the information provided above and discussed it with my therapist, and all of my questions have been answered to my satisfaction.

_____ _____

Signature of client/parent/legal guardian Date

_____ _____

Signature of therapist Date

