

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

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.

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.

I, _____, knowingly and willingly consent to participate in counseling, mental health support services or court ordered services with Jill Sanders, Ph.D., during the COVID-19 pandemic for myself and/or _____ (Name/DOB).

I understand that Jill Sanders, Ph.D. is taking the following precautions to protect clients and help slow the spread of the coronavirus.

- The office waiting room is not currently available for use. Clients will be asked to wait in their vehicles until Dr. Sanders texts you to come in for your session.
- The rooms Dr. Sanders uses for in person services have been arranged for appropriate physical distancing.
- Dr. Sanders will be wearing masks and asks for you to do the same. This is to protect both of us. If you have a need that prevents you from wearing a mask, please have a conversation with me.
- We will maintain safe distancing in our interactions with each other.
- The available restrooms are not exclusively for the use of Dr. Sanders' clients. You are encouraged to use the restroom at home as I am unable to guarantee the condition of our building restrooms. However, the building management assures me that the restrooms are undergoing more thorough and more frequent cleaning. Entrance to the restrooms is by key only. The key is on the reception desk and will be sanitized frequently.
- Hand sanitizer is available at the reception desk, as you enter and as you exit.
- Dr. Sanders is scheduling appointments at specific intervals to minimize the number of people in the office. Times may not be the same as you are used to.
- Only the client is allowed in the office at this time. Parents, siblings, and others are not able to enter the office for any reason unless otherwise instructed by Dr. Sanders.
- The front door is locked to prevent walk-ins.
- Areas that are commonly touched are thoroughly sanitized after each use.
- Tissues and trash bins are easily accessed. Trash is disposed of on a frequent basis.

- Common areas are thoroughly disinfected at the end of each day as well as throughout the day.

I/We are agreeing, based on this consent, to meet Face-to-Face/in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, either party may initiate that we meet via telehealth.

You understand that, if Dr. Sanders believes it to be necessary, she may determine that we switch to telehealth for everyone's well-being.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in Dr. Sanders changing your services to telehealth platforms.

Initial each to indicate that you understand and agree to these actions:

_____ 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.

_____ Your temperature may be requested to be taken and documented with a contactless thermometer.

_____ You confirm that you are not presenting any of the following symptoms of COVID-19 listed below:

- Temperature above 99.0 degrees
- Shortness of breath
- Loss of sense of taste or smell
- Dry cough
- Sore Throat
- Nausea
- Rash

_____ You will adhere to the safe distancing precautions Dr. Sanders has established.

_____ You will wear a mask in all areas of the office and recognize Dr. Sanders will be doing the same.

_____ You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands, hugging, etc.)

_____ You will try not to touch your face or eyes with your hands.

_____ 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. You understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and

still be contagious. It is impossible to determine who has it and who does not, given the current limits in virus testing.

_____ If you or anyone in your home have a job that exposes you to other people who are infected, you will immediately let Dr. Sanders know.

_____ If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will Dr. Sanders know.

_____ If a resident of your home tests positive for the infection, you will immediately let Dr. Sanders know and she will then begin telehealth sessions.

_____ As COVID continues to develop and professionals know more about it, you recognize the information in this consent 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.

_____ I agree that if I experience symptoms of COVID-19, or any potentially contagious symptoms, at any time within 14 days of my scheduled appointment, I will contact Dr. Sanders to cancel my appointment. I also understand that my session will be rescheduled if I show up for my appointment with presenting symptoms.

_____ I have not been around anyone with the known symptoms of COVID-19 in the past 14 days.

_____ I do not live with anyone who is currently sick or quarantined with COVID-19 symptoms.

_____ I have not traveled outside of the United States in the past 14 days.

_____ I have not traveled domestically within the United States by commercial airline, bus, or train within the past 14 days.

_____ I agreed to notify this office immediately if I exhibit any known symptoms of COVID-19 within 14 days of my last session.

<p>The limits of confidentiality are still in place, however if an exposure to COVID has occurred, my name (and/or child's name) and contact information could be released to official public health workers.</p>
<p>I understand that due to the visits of other clients to this office and the characteristics of the virus, that there may be some risk of contracting the virus simply by being in the office.</p>

Print/sign name Date

Therapist name/sign Date

