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Consent for In-Person Services

Decision to Meet Face-to-Face: You and your clinician have agreed to meet in person for some or all future sessions. Situations may arise; however, in which your clinician may require that you meet via telehealth. If you decide at any time that you would prefer staying with, or returning to, telehealth services, your clinician will respect that decision, as long as it is feasible and clinically appropriate. Many insurance companies are reimbursing for telehealth services at this time.

Risks of Opting for In-Person Services: An inherent risk of exposure to illness, including COVID-19, RSV, Influenza, etc., exists in any public place where people are present. According to the Centers for Disease Control and Prevention, senior citizens, people with underlying medical conditions, and people who are unvaccinated are especially vulnerable to illnesses. By coming to the office, you voluntarily assume all risks related to exposure to illnesses. This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibilities: To obtain services in person, you agree to take certain precautions which will help keep everyone safer. If you do not adhere to these safeguards, it will result in our starting / returning to a telehealth arrangement.

- You will only keep your in-person appointment if you are symptom free.
- **If any member of your household has symptoms of an illness, you will wear a surgical or N/KN-95 mask over your nose and mouth in all areas of the office, or switch to telehealth**.
- **If any member of your household tests positive for an infection, even if they are free of symptoms, you will wear a surgical or N/KN-95 mask over your nose and mouth in all areas of the office, or switch to telehealth.**
- If you are bringing your child, you will make sure that your child follows these protocols.

These precautions may change based on additional local, state or federal orders or guidelines.

I understand and agree to the above notice and agree to these procedures.

Patient Name: _____

Patient/Parent Signature: _____

Date: _____