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Consent for In-Person Services During COVID-19 Public Health Crisis

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 feel safer 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 COVID-19 exists in any public place where people are present. COVID-19 is an extremely contagious disease that can lead to severe illness and death. According to the Centers for Disease Control and Prevention, senior citizens and people with underlying medical conditions are especially vulnerable. By coming to the office you voluntarily assume all risks related to exposure to COVID-19. 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, your therapist, our families, other clinicians, front desk staff, and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it will 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. __
- You will wait in your car and call the office (631)928-4635 no earlier than 5 minutes before your appointment time to answer the screening questions. ___
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building. ___
- 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 sit where we have signs asking you not to sit.___
- You will wear a mask over your nose and mouth in all areas of the office. ___
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with anyone in the building. ___

- 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. ___
- 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 your clinician know. ___
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let your clinician know. ___
- If a resident of your home tests positive for the infection, you will immediately let your therapist know and you will then begin/resume treatment via telehealth.___

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

PRIVACY NOTICE:

Please be aware that in the event any of the patients, office colleagues, building personnel, or clinicians is suspected of having COVID-19, the NYS Department of Health and/or the CDC (or other official institutions) may require disclosure of names/addresses/phone numbers of all persons the infected person may have been in contact with. Normally, privacy rules prohibit this disclosure, but during outbreaks of illness where other people can be in danger, we may be obligated to provide this information to the authorities in order to prevent further spread of the disease.

I understand and agree to the above notice and change in privacy procedures.

Patient Name: _____

Patient/Parent Signature: _____

Date: _____