**INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PANDEMIC**

This document contains important information about our decision (yours and mine) to resume in-person psychotherapy for you or your child in light of the ongoing COVID-19 public health situation. 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 in-person**

We have agreed to meet in- person for some or all future sessions. However, we can revisit this decision at any time and stay with, or resume Telehealth services (online video appointments or phone sessions) if clinically appropriate to do so. For example, if there is a surge in cases or if other health concerns arise, I may require us to resume Telehealth services. Similarly, if you have concerns about meeting in-person, you can, at any time, request that we meet using Telehealth services instead.

**Risks of Opting for In-Person Services**

You understand that by coming to the office, you are assuming the risk of exposure to the COVID-19. My office is located in a building shared by other businesses and thus, you may come into contact with other people on your way to my office.

**Your Responsibility to Minimize Your Exposure**

When you decide that you would like to meet in-person, you agree to take certain precautions which will help keep everyone (you, me, other staff and other patients, our families and people close to us) safer from exposure. If you do not adhere to these safeguards, we may need to revert to Telehealth services.

You understand and agree that it will be your responsibility to take the following actions in order to help reduce the risk of exposure when we meet:

* You will cancel your in-person appointment if you have an elevated temperature (100 Fahrenheit +) or if you are experiencing any other symptoms associated with COVID-19 including cough, shortness of breath, sore throat, headache, muscle ache, fatigue, nausea/diarrhea, recent loss of sense of smell or taste. If you feel well enough, we will revert to Telehealth until you are symptom-free and can resume in-person meetings.
* You will wait in your car until no earlier than 5 minutes before our appointment tine.
* You will use alcohol-based hand sanitizer when you enter the office
* You will maintain social distancing in the lobby and in my office.
* You will wear a mask of face-covering (I will too)
* You will take steps between appointments to minimize your exposure to COVID-19 by following current public health guidelines.
* You will let me know if you have been in contact with someone who has tested positive for COVID-19 and we will revert to Telehealth.

**My Commitment to Minimize Exposure**

I share my office with one other colleague. Together, we have taken steps to reduce the risk of spreading COVID-19 within the office, including

* Providing alcohol-based hand sanitizer upon entry to the office (hallway) and in each office for use when you arrive and leave
* Cleaning and sterilizing surfaces before and after each appointment including door handles, tables, art supplies and toys.
* Minimizing the number of people in the office at any one time in accordance with Santa Clara County public health guidelines regarding density/square foot.
* Wearing a mask or face-covering when we meet
* Maintaining 6 feet of distance between us
* Minimizing my exposure to COVID-19 by following current public health orders and guidelines
* Saying informed of and responding to any changes in county, state or federal public health guidelines
* Notifying you if I have been in contact with another person who has tested positive for COVID-19 or is experiencing COVID-19 symptoms
* Offering Telehealth services if I am experiencing COVID-19 symptoms .

**Your Confidentiality in the Case of Infection**

If you have tested positive for COVID-19, 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. 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 and agreement for psychotherapy services. By clicking on the checkbox below, you indicate that you have reviewed and agree to the information provided in this document.

**Please indicate by signing that you have read and understood the information provided:**

I AGREE to the above: YES / NO (please circle one)

Client Name:

Client Signature : Date

Therapist Signature: Date