

## SomaticWise

### INFORMED CONSENT FOR IN-PERSON SERVICES DURING THE COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to begin/resume in-person services in light of the COVID-19 public health crisis. Our decision is based in part on recommendations by the Center for Disease Control (CDC), but other factors may be considered. Some of these include but are not limited to: whether we and our families have been vaccinated, our health or the health of those we are in close contact with, and risk of exposure outside of this setting. There may be other concerns that we can talk about.

Please read this carefully and let me know if you have any questions. Please place your initials in the spaces indicated. When you sign this document, it will be an official agreement between us.

#### **Decision to Meet Face-to-Face**

We have both agreed to meet in person for some or all future sessions. **INITIALS:**

\_\_\_\_\_

If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. **INITIALS:** \_\_\_\_\_

If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being. **INITIALS:** \_\_\_\_\_

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services may also be determined by the insurance companies and applicable law, so we'll discuss any financial implications if needed. Insurance plans vary considerably; you remain responsible for understanding and dealing with your own insurance plan. **INITIALS:**

\_\_\_\_\_

I have training in Ecopsychology and Ecotherapy, including a 100-hour certificate from Holos Institute. I am in the process of obtaining additional training in this body of work. As such, I sometimes meet with clients outdoors, in parks, urban nature preserves, or other nature-based settings. Therefore, meeting outdoors may be another option, depending on several variables. These variables may include clinical appropriateness, congruence with your treatment goals, and your comfort and capacity to meet in an outdoor setting. You understand that meeting outdoors is believed to substantially reduce the risk of COVID-19 transmission, but is not a guarantee of avoiding transmission. If you are interested, we may discuss this option for meeting outdoors.

**INITIALS:** \_\_\_\_\_

### **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, as well as the potential for exposure to other public health risks. This risk may increase if you travel by public transportation, cab, or ridesharing service. **INITIALS:** \_\_\_\_\_

### **Your Responsibility to Minimize Your Exposure**

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Initial each to indicate that you understand and agree to these actions:

- You will tell me if you've been vaccinated. If you haven't, we'll talk about the reasons and whether it's possible to meet safely in person. **INITIALS:** \_\_\_\_\_
- You will only keep your in-person appointment if you are free of symptoms that may indicate infection with COVID-19 or other transmissible illness. **INITIALS:** \_\_\_\_\_
- You will only keep your in-person appointment if you have been fever free for a minimum of 10 days prior to our appointment. **INITIALS:** \_\_\_\_\_
- You will cancel your in person appointment if you have been in contact with someone who has tested positive within the last 14 days. **INITIALS:** \_\_\_\_\_
- 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. If you wish to cancel for this reason, I won't charge you our normal cancellation fee. **INITIALS:** \_\_\_\_\_
- You will wait in your car or outside of the office, until no earlier than 5 minutes before our appointment time. Note: If you or your family members (or other people sharing the vehicle with you) are waiting in a car, please do not idle any gasoline powered vehicles in the parking lot, due to the noise and air quality concerns of our neighbors. **INITIALS:**  
\_\_\_\_\_
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building. **INITIALS:** \_\_\_\_\_
- You will adhere to any safe distancing precautions we have set up in the waiting room and therapy room. For example, you won't move chairs, or sit where I have signs asking you not to sit. **INITIALS:** \_\_\_\_\_
- You and I will wear masks while we are both in the office building. This requirement may change in the future, depending on CDC guidance, current virus numbers, national and state guidance and protocols, and/or other factors. Regardless of any such changes, you are welcome to wear a mask during in person sessions, as well as request that I do so. **INITIALS:**  
\_\_\_\_\_
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me. **INITIALS:** \_\_\_\_\_
- You will try not to touch your face or eyes with your hands. If you do, you will wash or sanitize your hands as soon as possible, and before touching anything else. **INITIALS:**  
\_\_\_\_\_

- You will not bring anyone other than yourself to our appointment, or into my office/waiting room, including children. The only exception is if you and I have discussed it ahead of time and I have agreed. **INITIALS:** \_\_\_\_\_
- You will take steps between appointments to minimize your exposure to COVID and will notify me if you have been in a higher risk situation. **INITIALS:** \_\_\_\_\_
- If you have a job that exposes you to other people who are infected, you will immediately let me know. **INITIALS:** \_\_\_\_\_
- If your commute, or other responsibilities or activities put you in close contact with others (beyond your family), you will let me know. **INITIALS:** \_\_\_\_\_
- If a resident of your home tests positive for the infection, you will immediately let me know. At that point, we will then begin or resume treatment via telehealth. **INITIALS:** \_\_\_\_\_

I 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.

### **My Commitment to Minimize Exposure**

My practice has taken steps to reduce the risk of spreading the coronavirus within the office, and I have posted my efforts on my website and in the office. Please let me know if you have questions about these efforts. **INITIALS:** \_\_\_\_\_

### **If You or I Are Sick**

You understand that I am committed to keeping you, me, and all of our families safe from the spread of this virus. If you show up for an appointment and I believe that you have a fever or other symptoms, or if I believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate. **INITIALS:** \_\_\_\_\_

If I test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

### **Your Confidentiality in the Case of Infection**

If you have tested positive for the coronavirus, it is possible that 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 and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release. **INITIALS:** \_\_\_\_\_

### **Informed Consent**

This agreement supplements the general informed consent and office policies that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

\_\_\_\_\_  
Patient/Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Psychotherapist

\_\_\_\_\_  
Date