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

This document contains important information about our decision to participate in in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions.

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 clients) safer from exposure, sickness and possible death.

- You will cancel your in-person appointment if you or anyone you have been exposed to has any signs of illness, including, but not limited to cough, shortness of breath, fever, chills, muscle aches, sore throat, headache.
- You will take steps between appointments to minimize your exposure to COVID-19.
- If you, a resident of your home, or anyone else with whom you have been in contact with tests positive for the infection, you will immediately let us know by phone, text, or email prior to any in-person appointments you have scheduled.
- You will be expected to answer questions regarding symptoms and possible exposure prior to each visit.
- You will continue to follow state and federal guidelines to minimize exposure to COVID-19 outside of your therapy time.

Our Responsibility to Minimize Your Exposure

In addition to following the same responsibilities above that we expect of you, Memory Partners OT will:

- Wear a mask and keep a 6 foot distance as much as possible.
- Sanitize all materials being used with a CDC recommended disinfectant.
- Have designated materials for you and all other materials will be able to be disinfected.
- Provide a mask for you if needed.

Your Confidentiality in the Case of Infection

If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in contact with me. 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.

Informed Consent

This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

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

Signature of patient or DPOA/Guardian : _____

Date: _____