INTOWN
COUNSELING & WELLNESS

COVID-19 Informed Consent & Waiver for In-Office Services

This document contains important information about your consent to in-office services during the COVID-19 pandemic. Please read this carefully. When you sign this document, it will constitute a contract between you and **Intown Counseling & Wellness, LLC**, (hereinafter referred to "The Practice"). The Practice cares about you and wants you to make an informed decision with your informed consent concerning in-office services. Please do not hesitate to call our office for additional information, or any concerns you may have.

Your Responsibility and Commitment to Minimize COVID-19 Exposure

To receive in-office services, you will need to sign this document and agree to take certain precautions to help keep your therapist, The Practice staff, our families, other clients, and the general public safer from exposure to COVID-19, illness, and possible death. By signing this document, you agree to follow "The Practice Policies for In-Office Services." **Please refer to our "Policies for In-Office Services" for more details.**

If you do not adhere to The Practice "Policies for In-Office Services," your appointment will be CANCELED, and you will have to call to reschedule and may be assessed a late cancelation fee. If clients generally do not comply with the policies, this will result in The Practice scheduling only telemental health appointments. **The Practice retains the right to deny appointments to anyone not complying with the policies** and maintains the right to require only telemental health arrangements for clients who we deem to be symptomatic, or otherwise a safety risk, in our sole discretion. The Practice may change the above precautions if additional local, state, or federal orders or guidelines are published. If that happens, we will notify you about any necessary changes.

Maintaining Confidentiality in the Case of Infection

If you have tested positive for the coronavirus and you have been in our office in the recent past, The Practice will need to inform identifiable people who you may have crossed paths with you, so they know they have had exposure. However, please know that if The Practice informs others, The Practice only informs them that a client tested positive; The Practice will not disclose your identity or any identifying information to anyone other than your treating

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therapist if you have not already done so. By signing this form, you agree that The Practice may do so without an additional signed release.

Please Read Carefully

1. You understand that The Practice is **NOT** responsible for the risk associated with in-office services and cannot be sued for any possible exposure to COVID-19. If your therapist or any other individual who has been in The Practice office contracts COVID-19 while seeking in-office services, you will not sue The Practice. As such, and in consideration of the services provided by The Practice, you individually and on behalf of your child(ren), hereby release, covenant not to sue, discharge, and hold harmless The Practice, its officers, employees, agents, and representatives of and from any and all claims, including all liabilities, actions, damages, costs or expenses of any kind arising out of or relating to in-office services or coronavirus exposure. You understand and agree that this release includes any claims based on the acts, omissions, or negligence of The Practice, its therapists, officers, employees, agents, and representatives, whether a coronavirus infection occurs before, during, or after participation in any in-person appointments.

2. You acknowledge and agree that if you have symptoms or have tested positive for coronavirus, you will inform The Practice, and you agree to seek treatment via telemental health and **will NOT return to in-office services until a medical doctor or nurse has given The Practice written authority to do so**. The Practice retains the right to cancel any appointment for any Client showing symptoms.

3. You understand and acknowledge that, by coming to the physical office, **you are responsible** for the risk of exposure to COVID-19 (or other public health risks).

4. You understand that by signing this document, you agree to follow **ALL** safety policies found in the **"Polices for Resuming In-Office Services,"** and you will follow the general CDC guidelines regarding COVID-19.

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

_____ _____

Patient/Client Date

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