

WEST MICHIGAN PSYCHOLOGICAL SERVICES

259 Hoover, Suite 140
Holland, Michigan 49423
616-460-0174



Informed Consent for In-Person Services During COVID-19 Pandemic

I, _____, consent to participate in in-person sessions with _____ (my therapist).

1. I understand the following with respect to in-person sessions during the COVID-19 pandemic:
 - a. I understand that COVID-19 is extremely contagious and is spread primarily by person-to-person contact.
 - b. I understand that my therapist has adopted reasonable preventative measures intended to reduce the spread of COVID-19, but there is still a possibility of transmission as a result of attending in-person therapy.
 - c. I understand that federal and state laws typically authorize public health departments to collect patient information to prevent or control disease and for related public health needs.
 - d. I understand that my therapist may be required to report COVID-19 related patient information to public health departments, HHS, or the CDC. For example, if anyone who has been in my therapist's office tests positive for COVID-19, disclosure may be necessary for contact tracing or other data collection needs. If reporting is required, only the minimum necessary information will be disclosed.
2. I agree to the following with respect to in-person sessions during the COVID-19 pandemic:
 - a. I will comply with safety precautions to limit the spread of COVID-19, as directed by my therapist.
 - b. I will notify my therapist as soon as possible before my appointment if I have symptoms of COVID-19 or have been exposed to certain risk factors as directed by my therapist. If this happens, I will cancel my appointment unless my therapist directs me to come in.

I knowingly and willingly consent to have in-person sessions during the COVID-19 pandemic, and I acknowledge the health risk of COVID-19 during this pandemic. I have read the information provided above and discussed it with my therapist, and all of my questions have been answered to my satisfaction.

Signature of client/parent/legal guardian

Date

Signature of therapist

Date

Safety precautions to limit the spread of COVID-19:

- Wait outside the office or in your car until the time of your appointment
- Maintain at least 6 feet distance between you and other people (including the therapist) in the office at all times

- We will decide together to wear a face mask or not while in the office
- Use hand sanitizer (to be provided) upon arrival in office and after touching your face

Symptoms of COVID-19:

- Fever over 100°
- Shortness of breath
- Dry cough
- Runny nose
- Sore throat
- Loss of sense of smell or taste

Risk factors for COVID-19:

- Tested positive for COVID-19
- Awaiting results of your own COVID-19 test
- In contact with someone in past 14 days who has tested positive for COVID-19
- Regularly in close contact with others outside of your family
- In prolonged contact with others outside of your family in past 14 days
- Traveled by air, bus, subway, train, or cruise ship in past 14 days

