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In-Person Services Disclosure and Agreement

This document contains important information about our decision (yours and mine) to begin/resume in-person services in light of COVID-19. 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. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face

We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. 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. 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 is also determined by the insurance companies and applicable law, so we'll discuss any financial implications if needed.

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 (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

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, Focus Forward Counseling and Consulting, Inc. staff 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.

- You will only keep your in-person appointment if you are symptom free.
- You will only keep your in-person appointment if you have been fever free for a minimum of 10 days prior to our appointment.
- You will cancel your appointment if you have been in recent contact with someone who has tested positive for COVID.
- If you have an elevated temperature (100° Fahrenheit or more), or if you have other symptoms of COVID or other illnesses, you agree to cancel the appointment or proceed using telehealth.
- If you have a job or activities that expose you to other people who are infected, you will immediately let me and Focus Forward staff know.

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.

Please initial that you have read this page _____

If You or I Are Sick
You understand that I am committed to keeping you, me, Focus Forward Counseling and Consulting, Inc. and all of our families safe from illness. If you show up for an appointment and I or my office staff believe that you have a fever or other symptoms, or 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.
If I test positive for COVID, 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, 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.

Informed Consent
This agreement supplements our general informed consent form.

ACCEPTANCE OF POLICIES, CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE:

I have read and do understand the contents of this form and agree to the policies of my relationship with my clinician and am authorizing my clinician to begin treatment with me. Further, FFCC may file on my behalf for payment of services with my insurance company and receive payment for these services directly. I agree that FFCC may release any and all records to my insurance company or payor as requested for the processing of my claim for services.

Please print, date, and sign your name below indicating that you have read and understand the contents of this form.

_____ _____
Client name (please print) Date

_____ _____
Client signature Date

If Applicable:

_____ _____
Parent's or Legal Guardian's name (please print) Date

_____ _____
Parent's or Legal Guardian's signature Date

The signature of the clinician below indicates that she or he has discussed this form with you and has answered any questions you have regarding this information.

_____ _____
Clinician’s signature Date

Please initial that you have read this page _____