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

This document contains important information about our decision (yours and mine) to resume or start 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. 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; that is, you have agreed for me to meet with you and/or your child in the clinic. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth or postpone sessions. 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 transition 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 has not been a problem; however, if your insurance plan disallows a claim you will still be responsible for session payments.

**Risks of Opting for In-Person Services**

You understand that by you or your child 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, our families, Clinic staff, and other clients) safer from exposure and possible serious illness. 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 only keep your in-person appointment if you are symptom free. \_\_\_
* You will do a coronavirus self-assessment (<https://bc.thrive.health/covid19/en>) before every session, and if you have any symptoms, you agree to cancel the appointment. If you wish to cancel for this reason, there will be no cancellation fee. \_\_
* You will adhere to the safe distancing precautions we have set up in the testing/therapy room. For example, you won’t move chairs or sit where we have asked you not to sit.\_\_\_
* You will wear a mask at all times in the building and waiting area. \_\_\_
* You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me or other staff. \_\_\_
* If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols. \_\_\_

I may change the above precautions if additional local, provincial or federal guidelines are enacted. If that happens, we will discuss any necessary changes.

**Our Commitment to Minimize Exposure**

Our training Clinic has taken steps to reduce the risk of spreading the coronavirus within the Clinic and we have posted our efforts within the office. Please let me know if you have questions about these efforts.

**If You or I Are Sick**

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

If I or our staff or colleagues 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, 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 the general informed consent/service agreement that we agreed to at the start of our work together.

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Therapist Date