Soffer & Associates

240 Central Park South, 8C

New York, NY 10019

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**Informed Consent for In-Person Services During the COVID-19 Public Health Crisis**

This document contains important information about our decision (yours and mine) to resume 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 you and me.

**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.

**If You or I Are Sick**

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

If I 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/your child have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I must 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 service agreement that you signed at the start of our work together.

I attest that:

* + I/my child am/is not experiencing any symptom of illness, such as cough, shortness of breath or difficulty breathing, fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell.
  + I do not believe I/my child have been exposed to someone with a suspected and/or confirmed case of the Coronavirus/COVID-19.
  + I/my child have/has not been diagnosed with or suspected to have Coronavirus/Covid-19 and not yet cleared as non-contagious by state or local public health authorities.
  + I/my child am/is following all federal, state, and local laws and recommended guidelines as much as possible and limiting my exposure to the Coronavirus/COVID-19.
  + I/my child will follow all instructions, recommendations, and cautions of Soffer & Associates at all times, including, without limitation, requirements related to hand sanitation, social distancing, and use of face coverings.
  + I/my child have/has not traveled internationally within the last 14 days.
  + I/my child have/has not traveled to a highly impacted area within the United States of America in the last 14 days. If so, please tell us where you traveled to and your dates of travel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I acknowledge the following:

* + The contagious nature of the Coronavirus/COVID-19 and that the CDC and many other public health authorities still recommend practicing social distancing.
  + Soffer & Associates has put in place preventative measures to reduce the spread of the Coronavirus/COVID-19.
  + Soffer & Associates cannot guarantee that I/my child will not become infected with the Coronavirus/COVID-19. I understand that the risk of becoming exposed to and/or infected by the Coronavirus/COVID-19 may result from the actions, omissions, or negligence of myself and others, including, but not limited to, counseling staff, and other clients and their families.
  + NOTWITHSTANDING THESE RISKS, I ACKNOWLEDGE THAT I AM VOLUNTARILY PARTICIPATING IN THE SERVICES PROVIDED BY SOFFER & ASSOCIATES WITH KNOWLEDGE OF THE DANGERS INVOLVED. I HEREBY AGREE TO ACCEPT AND ASSUME ALL RISKS OF INJURY, ILLNESS, DISABILITY, DEATH, AND/OR PROPERTY DAMAGE ARISING FROM SERVICES PROVIDED BY SOFFER & ASSOCIATES, WHETHER CAUSED BY THE ORDINARY NEGLIGENCE OF SOFFER & ASSOCIATES OR OTHERWISE.
  + I will comply with all set procedures to reduce the spread while attending my appointment.
* I hereby release and agree to hold Soffer & Associates harmless from, and waive on behalf of myself, any and all causes of action, claims, demands, damages, costs, expenses, including legal expenses, and compensation for damage or loss to myself and/or property that may be caused by any act, or failure to act, of the practice, or that may otherwise arise in any way in connection with any services received from Soffer & Associates. I understand that this release discharges Soffer & Associates from any liability or claim that I, my heirs, or any personal representatives may have against the practice with respect to any bodily injury, illness, death, medical treatment, or property damage that may arise from, or in connection to, any services received from Soffer & Associates. This liability waiver and release extends to the practice together with all therapists and other employees.

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

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Patient/Client or Patient’s/Client’s Parent/Guardian Date

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Evaluating Psychologist Date