



## **INFORMED CONSENT FOR IN-PERSON TREATMENT DURING THE COVID-19 CRISIS**

### **Decision to Meet Face-to-Face**

If we mutually decide to meet in person (Face-to-Face, hereinafter - F2F) for some or all future counseling sessions, precautions must be in place to mitigate the COVID-19 pandemic. This document contains information about those precautions and guidelines to safely meet F2F. Your signature(s) below indicates that you understand and agree to undertake these actions concerning all F2F appointments. Please read this carefully and let me know if you have any questions.

If we mutually decide to meet in person (F2F) and there is a subsequent resurgence of the pandemic, or subsequent changes in local, state, or federal guidelines, or if other health concerns arise, I may require that we meet via teletreatment. If you decide at any time that you would prefer teletreatment, I will respect that decision, provided it is clinically appropriate.

Also be mindful that if your clinician files for reimbursement for any teletreatment services, such reimbursement is determined by insurance companies and applicable law. You are responsible for payment whether services are provided via teletreatment sessions or F2F, and whether insurance companies reimburse or not.

### **Risks of Opting for In-Person F2F Services**

Although there are potential benefits for in-person F2F counseling, there are also risks. You understand that by attending F2F sessions, you would be assuming the risk of exposure to the coronavirus, or other public health risks, and that this risk may increase if you travel by public transportation, cab, or ridesharing service.

In consideration of the services of The Well Clinic (hereinafter TWC) and my clinician, I hereby agree to release, indemnify, defend and discharge both TWC and my clinician, on behalf of myself, my spouse, my children, my parents, my heirs, assigns, personal representative and estate as follows:

I have been offered by TWC and my clinician to conduct the treatment session remotely via Zoom or other online means, however, I desire a face to face treatment session. I am aware of the risk of infection with COVID 19 and I understand that such risk simply cannot be eliminated without completely avoiding a face to face treatment session.

I expressly agree and promise to accept and assume the risk of infection with COVID 19 existing in a F2F treatment session. My participation in a F2F treatment session at TWC and with my clinician is purely voluntary, and I elect to participate in spite of the risks.

### **Your Responsibility to Minimize Your Exposure**

To obtain counseling in person (F2F), and signing this document, you will take the following precautions which will help keep all of us (you, me, our families, my staff, and other clients) safer from exposure, sickness and possible death. Failure to adhere to these safeguards, may result in our starting or returning to a teletreatment arrangement.

**17534 Old Jefferson Hwy, Suite B2  
Prairieville, LA 70769  
225-692-4113**

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- If you reasonably believe that you have recently been exposed to, are infected with, or have symptoms of the coronavirus, you will cancel your F2F appointment or proceed using teletreatment.
- You will wait in your car or outside until no earlier than 5 minutes before your appointment time.
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building.
- You can wear a mask in all areas of the office, and you can request that our staff do the same. Clients agree to:
  - bring their own face mask that covers their nose and mouth.
- You will adhere to the safe distancing precautions.
- You will keep a distance of 6 feet from all other persons and there will be no physical contact (i.e. no shaking hands) with me, other clients, or with my staff.
- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands.
- You will not bring guests and/or non-client children to TWC.
- You will take steps between F2F appointments to minimize your exposure to COVID-19.
- If you have a job, other responsibilities, or activities that put you in close contact with others infected with COVID, you will notify me immediately.
- If a resident of your home tests positive for the coronavirus infection, you will notify me immediately. Continuing treatments will be conducted via teletreatment until quarantine is over.
- To minimize contact with support staff, you will do all scheduling of appointments either online through the Treatment Appointment software, or over the phone with support staff.
- To minimize the exchange and handling of payment(s), you will have your credit card information on file with TWC at least one day prior to the counseling session.

I reserve the right to change the above precautions if additional local, state, or federal orders or guidelines are published. If that happens, you will be notified about any necessary changes.

### **My Commitment to Minimize Exposure**

My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in 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, my staff, all clients, and all of our families safe from the spread of this virus. 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 teletreatment as appropriate.

If I, or my staff, test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

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**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 am required 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 your 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/business agreement that we agreed to at the start of our work together.

Your signature(s) below shows that you agree to and will abide with these terms and conditions. By signing this document, I acknowledge that I waive my right to maintain a lawsuit against TWC and my clinician on the basis of any claim that I released herein. I also agree to pay TWC and my clinician attorneys' fees and costs in enforcing this agreement.

\_\_\_\_\_  
Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client (if couple, both sign)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinician

\_\_\_\_\_  
Date

*Written incorporating sample-informed-consent-form-1 from APA-1  
C. Andrew Yarborough, Psy.D., LCP #1161 (LA)*

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