

# CARE-LA

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## INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about a mutual decision to resume in-person services in regards to the COVID-19 public health crisis. Please read this carefully and let us know if you have any questions. When you sign this document, it will be an official agreement between you and CARE-LA.

### 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, we may require that we resume telehealth meetings.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, we will respect that decision, as long as it is feasible and clinically appropriate.

### Risks of Opting for In-Person Services

You understand that by coming to the office or having us come to your home, 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, us, and our families, [other 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. 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 wait in your car or outside [or in a designated safer waiting area] until no earlier than 5 minutes before the appointment time. \_\_\_\_
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building. \_\_\_\_
- You will adhere to the safe distancing precautions. \_\_\_\_
- You will wear a mask in all areas of the office (the therapist [and our staff] will too). \_\_\_\_
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with the therapist [or staff]. \_\_\_\_
- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols. \_\_\_\_
- If you have a job that exposes you to other people who are infected, you will immediately let the therapist [and our staff] know. \_\_\_\_
- If your commute or other responsibilities or activities (e.g. protests) put you in close contact with others (beyond your family), you will let the therapist [and our staff] know. \_\_\_\_
- If a resident of your home tests positive for the infection, you will immediately let us know and

we will then begin or resume treatment via telehealth.\_\_\_\_

We 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.

**If You or We Are Sick**

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

If anyone on our staff test positive for the coronavirus, we 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, we may be required to notify local health authorities that you have been in the office. If we have to report this, we 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 we may do so without an additional signed release.

**Informed Consent**

This agreement supplements the general informed consent/business agreement that was agreed upon at the start of our work together.

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

\_\_\_\_\_  
Patient or Parent (if minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider

\_\_\_\_\_  
Date