PATIENT ACKNOWLEDGMENT OF, ACCEPTANCE OF, AND INFORMED CONSENT TO POSSIBLE RISKS OF IN-PERSON TREATMENT DURING COVID-19 PUBLIC HEALTH CRISIS

I _____(*Patient Name*) have elected to pursue in-person psychiatric treatment during the COVID-19 pandemic from _____(*Doctor's Name or Practice Name*), who is fully vaccinated against Covid-19.

By signing this, I attest that:

1. I am fully vaccinated against COVID-19 according to the CDC (i.e. it has been more than 2 weeks since I received either the second dose in a 2-dose series vaccine or a single-dose vaccine);
2. I will only attend my in-person appointment if I am asymptomatic. If I should develop symptoms consistent with COVID-19 prior to my appointment, I will not go into the office and will make arrangements with [*Dr.'s Name*]'s office to transfer the appointment to a virtual one;
3. In the past 7 days, I have not had any of the following symptoms consistent with COVID-19: (i) a fever (higher than 100.4 F) or chills, (ii) cough, (iii) shortness of breath or difficulty breathing, (iv) fatigue, (v) muscle or body aches, (vi) headache, (vii) new loss of tase or smell, (viii) sore throat, (ix) congestion or runny nose, (x) nausea or vomiting, (xi) diarrhea; and
4. I will immediately notify the office if I am diagnosed with Covid-19 after my in-person treatment, and make arrangements with [*Dr.'s Name*] for virtual treatment during any time period during which the CDC recommends that I should be in isolation or quarantine.
5. I have not knowingly had close contact with anyone infected with COVID-19 in the past 14 days.

I acknowledge that there may still be health risks involved in visiting the office and having face-to-face contact with [*Dr.'s Name*]. I understand and voluntarily accept those risks and have elected to receive my psychiatric care in person. I hereby release and waive any right to bring suit or otherwise make any claim against [*Dr.'s name and/or Practice Name*] in connection with exposure, infection and/or spread of COVID-19 related to my in-person treatment.

I further acknowledge that if there is resurgence of the virus or if other health concerns arise, including a period of isolation/quarantine for [*Dr.'s Name*], she/he/they may choose to return my visits to a virtual format. In such event, [*Dr.'s Name*] and I will discuss the reasons for this and make arrangements for continuing care virtually. I understand that I may elect to return to telehealth visits at any time.

If I am diagnosed with COVID-19, I understand and give my consent for [*Dr.'s Name*] to comply with all required notifications to health authorities by providing the minimum necessary information for their data collection. By signing this form, I agree to this without the necessity of any additional release.

This PATIENT ACKNOWLEDGEMENT OF, ACCEPTENCE OF AND INFORMED CONSENT TO POSSIBLE RISKS OF IN-PERSON TREATMENT DURING COVID-19 PUBLIC HEALTH CRISIS supplements the general informed consent and other business agreements I have agreed to with [*Dr.'s Name*] during our work together.

Acknowledge, Accepted and Agreed to this ____ day of _____ 2021

BY: _____
Patient Signature

_____
Printed Patient Name