JANEEN SAMARTINO, LCPC

Patient Information

PATIENT INFORMATION - PLEASE PRINT CLEARLY					
NAME (Last, First, Middle)			SSN#	BIRTHDATE	SEX
ADDRESS			CITY, STATE, ZIP		
HOME PHONE	WORK PHONE	CELL PHONE	EMAIL		
EMPLOYER		EMPLOYER ADDRESS			

RESPONSIBLE PARTY INFORMAITON (If Different than above)					
NAME (Last, First, Middle)			SSN#	BIRTHDATE	SEX
ADDRESS			CITY, STATE, ZIP		
HOME PHONE	WORK PHONE	CELL PHONE	EMAIL		
EMPLOYER		RELATIONSHIP TO PATIENT			

PRIMARY INSURANCE		
NAME OF INSURANCE COMPANY		POLICY# OR ID #
NAME OF INSURED	INSURED DATE OF BIRTH	GROUP#
INSURED ADDRESS		COPAY
CITY, STATE, ZIP		DEDUCTIBLE
RELATIONSHIP TO PATIENT		EFFECTIVE DATE

SECONDARY INSURANCE (If Applicable)		
NAME OF INSURANCE COMPANY		POLICY# OR ID #
NAME OF INSURED	INSURED DATE OF BIRTH	GROUP#
INSURED ADDRESS		COPAY
CITY, STATE, ZIP		DEDUCTIBLE
RELATIONSHIP TO PATIENT		EFFECTIVE DATE

I authorize the relase of any medical or other information necessary to process claims, including information related to Mental Health, and Substance Abuse. I authorize payment of medical benefits to the physician or supplier for all services rendered. I undertand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional serices rendered.

SIGNATURE OF PATIENT/GUARDIAN

DATE

JANEEN SAMARTINO, LCPC
Assignment of Benefits/Release of Information

Patient: _____

I,_____, understand that services rendered to me by **Janeen Samartino, LCPC** are my financial responsibility and that the provider will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to **Janeen Samartino, LCPC** and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance company.

I authorize the provider to release any information necessary to adjudicate the claim and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to **Janeen Samartino, LCPC** within 48 hours. I agree that if I fail to send the payment to the provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies.

I authorize **Janeen Samartino, LCPC** to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Dated_____ Witness _____

_____ _____

Signature of Policyholder Patient or Guardian

WELCOME TO THE OFFICE OF JANEEN M. SAMARTINO, MA., LCPC.
1655 N. Arlington Heights Road, Suite 303E
Arlington Heights, IL 60004
T: 847-638-3700
F: 847-670-6075

Service Agreement & Informed Consent for Treatment

Thank you for choosing Janeen M. Samartino, MA., LCPC. This **Service Agreement & Informed Consent for Treatment** contains important information about my services and business policies, state and federal laws, and your rights. Please read this information before signing. If you have any questions or concerns about this agreement, now or in the future, please let me know at your earliest convenience, so that we may address such issues as they arise. My treatment practices, philosophy, and risks and benefits of clinical professional counseling, including psychotherapy, will be discussed with you today. Our appointment today will take approximately 45-60 minutes.

CONFIDENTIALITY & EMERGENCY SITUATUONS:

My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and we have discussed those issues. You may ask me questions about confidentiality at any time.

You have an absolute right to confidentiality related to my services, except for those authorized uses and disclosures outlined in the Notice of Privacy Practices. Moreover, the following are legal exceptions to your right to confidentiality:

a. If I have reason to believe that a child under 18 years old, an elderly, mentally ill, or disabled person is being abused or neglected, then I am obligated by law to report this situation to the appropriate state agency or authority.
b. If I have reason to believe that you are threatening immediate physical harm to yourself, and if you are unwilling or unable to follow treatment recommendations, then I may have to contact a family member or another person who may be able to help ensure your safety. If I am unable to ensure your safety, then I am required by law to call 911, seek hospitalization, or a combination of these actions.
c. If I have reason to believe that you are threatening physical violence against another person, or if you are an actual threat to the safety of another person, then I am required by law to take action to ensure that the other party is safe. This means I may contact the police, notify the other person(s), seek hospitalization, or a combination of these actions.
d. If you present as a clear and present danger to yourself or others, developmentally or intellectually disabled, then I am mandated to report you to the Department of Human Services.

In the event that one of the foregoing emergency situations arises, I authorize Janeen M. Samartino, MA., LCPC. to contact the following individual whom I designate as my emergency contact:

Name: _____ Relationship: _____
Primary Phone: _____ Alternate Phone: _____

Signature: _____ **Date:** _____

RECORDKEEPING POLICY

I am required to keep appropriate records of the services I provide. Your records are maintained in a secure location. I keep brief records noting only that you have been here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social and treatment history, records I receive from other providers, copies of records I send to others and billing records. You have the right to a copy of your file. In the unlikely event that I am unable to provide ongoing services Nanette Stevenson of PMB Inc. will maintain your records for 7 years. She can be reached at 708-362-6080.

FINANCIAL POLICY:

Rates: Diagnostic Session $160 Individual Therapy Session $140 Family/Couples Session $140

Health Insurance: As a courtesy, for the plans in which I maintain a contractual relationship, claims will be filed with your insurance company through **Priority Medical Billing INC.** Full payment of your services will be collected until your deductible and your co-insurance rate are determined. You will be responsible at the time of service for all co-pays, co-insurance, and services not covered by your plan. If a deductible has not been met the full fee is due at each session until it is satisfied. Full payment is due at time of service via cash, personal checks, and credit cards. Financial responsibility for services rendered rest with the client regardless of insurance coverage. If your insurance company denies payment or does not cover services, the balance will be due at the time of service. Credit card information will be on file and will be charged for balances that remain after 60 days.

Signature: _____ **Date:** _____

CANCELATION POLICY:

Once an appointment time is agreed upon, that time is reserved for you. **24 hour notice is required if you need to cancel or reschedule an appointment otherwise a fee of $100 will be applied.** Insurance companies cannot be billed for missed sessions. Extenuating circumstances are considered when appropriate.

Signature: _____ **Date:** _____

CONSENT FOR TELEPHONE, ELECTRONIC MAIL, AND CRISIS CONTACT

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to reach me by phone. I will try to return your call within 24 hours except on weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician. **In the event of an emergency, call 911 or go to your nearest emergency room.** You may leave me a confidential voicemail message at 847-638-3700. **Communication via voicemail, fax, email, mail, text, and other such means are by no means secure.** While I welcome communication via such means, absolute confidentiality is never guaranteed. I strive to make every effort to protect your information, however, **I cannot guarantee absolute privacy**. Your use of such means of communication constitutes implied consent for reciprocal use of electronic and mail communication. By signing below, you agree that you accept the above stated risks. Your signature below also indicates you will **not** use email and/or text for discussing lengthy clinical concerns. Instead, you agree that emails and texts will be utilized for scheduling and other administrative matters.

It is your right to let me know how you would like to be contacted. Please indicate below whether I may contact you at home, on your cell phone, or by email.

May I contact you at home? Yes/No May I contact you by cell? Yes/No May I contact you by email? Yes/No

May I leave a voice message? Yes/No

Signature: _____ **Date:** _____

COORDINATION OF TREATMENT

Often it is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician, obstetrician/gynecologist, and/or psychiatrist. Your consent is valid for one year. If you prefer to decline consent, no information will be shared. This authorization may be revoked at any time.

[ ] Yes, I give consent for you to communicate with the following provider(s).

Physician Name: _____

Phone Number: _____

[ ] No, I decline consent for you to communicate with my provider(s).

Signature: _____ **Date:** _____

[IF APPLICABLE] CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS

I/We consent that _____ may be treated as a client by Janeen M. Samartino, MA., LCPC. It is understood that children over the age of 12 have confidentiality protected by law. This consent to treat expires at the end of treatment or if revoked in writing.

Signature: _____ **Date:** _____

Printed Name: _____

Signature: _____ **Date:** _____

Printed Name: _____

By signing below, you acknowledge that you have read this Service Agreement & Informed Consent for Treatment, had sufficient time to consider it carefully, asked any questions that you need to, and understand its terms. You understand the limits to confidentiality required by law. You understand your rights and responsibilities as a client and agree to abide by all policies, terms, and conditions outlined above.

Your signature below further indicates that you consent to therapy with Janeen M. Samartino, MA., LCPC. You further understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, you understand that while you may benefit from therapy, results cannot be guaranteed or assured.

Client Signature: _____ **Date:** _____

Counselor Signature: _____ **Date:** _____

Janeen M. Samartino, MA., LCPC.

Notice of Privacy Practice (Short Form)

Revised March 17, 2022

This Notice of Privacy Practices (Short Form) ("Notice") describes how medical information about you may be used and disclosed and how you can obtain access to this information. **Please review this Notice carefully.**

The terms of this Notice apply to Janeen M. Samartino, MA., LCPC. I only share protected health information of patients for treatment, payment and health care operations as permitted by law and for the purposes described herein. This document is the short form of my full Notice of Privacy Practices. The complete version of my Notice of Privacy Practices which contains detailed information regarding how your protected health information may be used and disclosed will be provided upon your request. I am required by law to abide by the terms of this Notice and my full Notice of Privacy Practices for as long as it remains in effect. I reserve the right to change the terms of this Notice as necessary and to make a new Notice effective for all personal health information collected. If there is a provision of state law that relates to the privacy of your health information that is stricter (or more protective of you) than a standard or requirement under HIPAA, then I will comply with the stricter (or more protective) standard.

Your Privacy Official Contact is Janeen M. Samartino, MA., LCPC. All communications described herein should be made in writing and sent to the Privacy Official at the following address: 1655 N. Arlington Heights Road, Suite 303E, Arlington Heights, Illinois 60004.

I may use or share your health information in the following ways: (1) for treatment, such as coordination and management of your care; (2) to bill for your services, such as providing information to your health insurance company to bill and get paid; and (3) for healthcare operations, such as for my own business activities, including billing, completing treatment authorizations for insurance purposes and to improve your care through quality assurance. If I want to or you want me to use or disclose your protected health information for any other purposes, other than as required by law or as described in this document, I will discuss this with you and ask you to sign a HIPPA Authorization Form to allow such disclosure.

In certain circumstances, I am permitted or required to disclose you protected health information without a signed HIPPA Authorization Form from you, which are described in detail in the full version of my Notice of Privacy Practices. Examples of such circumstances include, but are not limited to: situations in which you are given the opportunity to verbally agree or object to such disclosure; if I am required to make a disclosure by law; if I am required to make a disclosure for public health activities; if I believe such a disclosure is necessary to prevent a serious or imminent threat to the health or safety of the public; and if I am required to make such a disclosure to comply with worker's compensation laws.

You have the following rights with respect to your protected health information: (1) get an electronic or paper copy of your medical record; (2) ask me to correct your medical record; (3) request confidential communications; (4) ask me to limit what I use or share about you; (5) ask me to limit what I use or share; (6) get a list of whom I've shared information about you; (7) get a copy of this Notice or the full version of my Notice of Privacy Practices; (8) choose someone to act for you; and (9) file a complaint if you feel your rights are violated by contacting the Privacy Official or filing a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. You will not be penalized or retaliated against for filing a complaint.

I am required by law to maintain the privacy and security of your protected health information. I will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. I must follow the duties and privacy practices described in this notice and give you a copy of it. I will not use or share your information other than as described here unless you tell me I can in writing. You may change your mind at any time. Let me know in writing if you change your mind.

By signing below, I acknowledge receipt of this Notice. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Janeen M. Samartino, MA., LCPC. I understand that the revocation will not apply to information that has already been released in compliance with this authorization.

_____ _____

Signature of Client/Personal Representative Date

_____

Print Name

_____

Personal Representative Title
(e.g., Parent, Legal Guardian, Health Care Power of Attorney)

Janeen M. Samartino, MA., LCPC.
1655 N. Arlington Hts. Rd., Suite 303E, Arlington Heights, IL. 60005
847-638-3700

AUTHORIZATION TO RELEASE INFORMATION:

I. I the undersigned, hereby give permission to have Janeen M. Samartino, MA, LCPC., to release and/or obtain protected health information on the individual named below

Patient Name: _____ D.O.B ____/____/____ Age:_____

Address: _____
Street City State Zip

Home Ph:_____ Cell Ph:_____ Work Ph._____

II. The following information may be Released & Obtained for the following individual(s)/organizations

Recipient Name: _____ Recipient Phone: ( )_____
Recipient Fax: ( ) _____

Address: _____
Street City State Zip

III. The following information may be Released and Obtained (Please check all that apply)**:**

___Continuity of Care
___Diagnosis
___Testing Information
___Billing Information
___Progress in treatment
___Academic Records
___Educational Information
___Medical Records
___Medication List
___Other (Your description should be as accurate as possible)
___Psychiatric Evaluation(s)
___Treatment plan/summary
___Behavioral Observations
___Assessment

_____

IV. I understand that this Release of Information is voluntary. I may cancel this consent to release information at any time via written notice to Janeen M. Samartino at the address listed above. I further understand that Janeen M. Samartino does not require this form as a condition of treatment. This form shall remain in effect for one year from the date of signature, unless previously revoked or otherwise indicated here:

_____
(fill in expiration date)

_____ _____
Client's Signature (Children over age 12 must sign) *Client's Printed Name*

_____ _____
Parent/Guardian's Signature (if applicable) *Parent/Guardian's Printed Name*

_____ _____
Witness' Signature *Witness' Printed Name*

Date: _____

Janeen M. Samartino, MA., LCPC.
1655 N. Arlington Hts. Rd., Suite 303E
Arlington Heights, IL. 60005
847-638-3700

Authorization for Credit Card Billing

In order to ensure payment is processed at the time of service, Janeen M. Samartino, MA., LCPC., allows for credit card authorization to be protected on file. Please complete the information below for convenient billing.

Patient Name: _____

I, _____, authorize Janeen M. Samartino, MA., LCPC., to charge my credit card for the *initialized* reasons below:

Service Fees: Pay for copays, deductibles, session charges, and other fees due at time of service.

(Please initial)_____

Balances on the Account: Pay balances on your account not covered by insurance, as well as balances 60 days past due, including delinquent accounts.

(Please initial)_____

Missed Sessions: Pay charges for missed session fee, if there is a failure to cancel within 24 hours of your scheduled appointment.

(Please initial)_____

Name as it appears on Card: _____

Credit Card Number: _____-_____-_____-_____

Security Code: _____

Expiration Date: _____ Address: _____

_____

I authorize Janeen M. Samartino, MA., LCPC., to keep my signature on file for future charges authorized by me as indicated above. I understand that this form is valid, and I agree to inform Janeen M. Samartino, MA., LCPC., of any changes to the above information with-in 14 days . If the above credit card is declined for any reason, I agree I will be responsible for acquired fees. I also agree that if my credit card becomes invalid, I will provide payment information with another valid credit card. By signing below, I accept the terms to charge my credit card.

Cardholder's Signature: _____ ***Date:*** _____

JANEEN M. SAMARTINO, MA., LCPC.
1655 N. Arlington Heights Road, Suite 303E
Arlington Heights, IL 60004
T: 847-638-3700
F: 847-670-6075

Informed Consent for Telehealth Services

This **Informed Consent for Telehealth** contains important information about using telehealth for clinical professional counseling. Please read this carefully and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

BENEFITS AND RISKS OF TELEHEALTH

Telehealth refers to providing clinical professional counseling services remotely using interactive telecommunications technologies, such as video conferencing or telephone. One of the benefits of telehealth is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telehealth, however, requires technical competence on both our parts to be helpful. Although there are benefits of telehealth, there are some differences between in-person and telehealth services, as well as some risks. For example:

- **Risks to confidentiality**. Because telehealth sessions take place outside of the clinician's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end, I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in clinical professional counseling only while in a room or area where other people are not present and cannot overhear the conversation.
- **Issues related to technology**. There are many ways that technology issues might impact telehealth. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.
- **Crisis management and intervention**. Usually, I will not engage in telehealth with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telehealth, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telehealth work.
- **Efficacy**. Most research shows that telehealth is about as effective as in-person services. However, some clinicians believe that something is lost by not being in the same room. For example, there is debate about a clinician's ability to fully understand non-verbal information when working remotely.

ELECTRONIC COMMUNICATIONS

I use doxy.me.com in my practice as the platform for telehealth services. You may have to have certain computer or cell phone systems to use telehealth services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telehealth services.

For communication between sessions, I only use email communication and text messaging with your permission and only for administrative purposes. This means that email exchanges and text messages with me should be limited to administrative matters. This includes things like setting and changing appointments, billing matters, and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not discuss any clinical information by email or text and prefer that you do not either.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to reach me by phone. I will try to return your call within 24 hours except on weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact in my absence if necessary.

CONFIDENTIALITY

I have a legal and ethical responsibility to use my best efforts to protect all communications that are a part of telehealth services. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telehealth sessions and having passwords to protect the device you use for telehealth).

The extent of confidentiality and the exceptions to confidentiality that I outlined in my Notice of Privacy Practices and Services Agreement & Informed Consent still apply in telehealth. Please let me know if you have any questions about exceptions to confidentiality.

APPROPRIATENESS OF TELEHEALTH

From time to time, we may schedule in-person sessions to "check-in" with one another. I will let you know if I decide that telehealth is no longer the most appropriate form of treatment for you. We will discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

EMERGENCIES AND TECHNOLOGY

Assessing and evaluating threats and other emergencies can be more difficult when conducting telehealth sessions than in traditional in-person services. To address some of these difficulties, we will create an emergency plan before engaging in telehealth services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back; instead, call 911, or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and try to reconnect. If you are unable to reconnect, call me at 847-638-3700.

If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

FEES

The same rates will apply for telehealth services as apply for in-person services. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover telehealth sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in telehealth sessions to determine whether these sessions will be covered.

RECORDS

Telehealth sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

INFORMED CONSENT

This agreement is intended as a supplement to the Services Agreement & Informed Consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions. If at any time you wish to withdraw your consent for telehealth services, please provide written notification to Janeen M. Samartino, MA., LCPC.

Client Full Name: _____ DOB: _____

Client Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____

Counselor Signature: _____ Date: _____

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 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 Janeen M. Samartino, LCPC.

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, I may require that we meet via telehealth. 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 return 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, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

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.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, 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.

- You will only keep your in-person appointment if you are symptom free.
- You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, I won't charge you our normal cancellation fee.
- You will text me from your car, wait in your car or outside until I text you that it is okay to walk into the office no earlier than 5 minutes before our appointment time.
- You will wash your hands or use alcohol-based hand sanitizer when you enter my office.
- You will adhere to the safe distancing precautions we have set up when you enter my office location.
- You will wear a mask in all areas of the office (I will too).
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me [or 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.

- If another family member of your family is joining our sessions, they will be required to follow all of these sanitation and distancing protocols.
- You (and myself) will take steps between appointments to minimize your exposure to COVID.
- If you have a job that exposes you to other people who are infected, you will immediately let me know.
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me know.
- If a resident of your home tests positive for the infection, you will immediately let me know and we will then [begin] resume treatment via telehealth.

I 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.

My Commitment to Minimize Exposure

My practice has taken steps to reduce the risk of spreading the coronavirus within the office. Masks will be worn at ALL times. Doors will be open when you enter (and I will open when you leave), outer door will be locked during sessions and the other doors will be left open, where you sit or touch will be wiped down after each use. 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 and me, and all of our families safe from the spread of this virus. If you show up for an appointment and I 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 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 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/business agreement that we agreed to at the start of our work together.

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

_____ _____

Patient/Client Date

_____ _____

Therapist Date