Counselors Associates Ltd
Here to help.

Intake Client Information

Today's Date: _____ **Counselor's Name:** _____

Patient Name: _____ _____ _____
(Last Name) (Middle Initial) (First Name)

Patient Address: _____

City: _____ **State:** _____ **Zip code:** _____

Patient Date of Birth: _____ **Age:** _____

Primary Email: _____

Preferred Phone #: _____ **Preferred contact method?** ☐Call or ☐Email

Emergency Contact: _____ _____
(Full Name) (Relationship to Patient example: Friend)

_____ _____
(Email) (Phone Number)

Gender: _____ **Pronouns:** _____

Marital/Partner Status: ☐Married ☐Single ☐Other: _____

Employment: ☐Employed ☐Unemployed ☐Student ☐Other: _____

Administrative Sex for Insurance Claims: ☐Female ☐Male ☐Other: _____
(*Use value the insurance company has on file.)

If the patient is a minor, responsible party information: _____
(Relationship to Patient example: Mom/Dad/Guardian)

_____ _____
(Full Name) (Date of Birth MM/DD/YYYY)

_____ _____
(Email) (Phone Number)

_____
(initials)

By providing this contact information, you are giving Counselors Associates Ltd permission to call, leave a message and/or email you at the above phone number and/or email address for appointment reminders, treatment alternatives and/or recommendations, and/or healthcare-related services.

• Phone: 618-972-1568 • Billing: 618-972-2866 • Fax: 618-205-3561
• Contact Email: info@counselorsassociates.com • www.counselorsassociates.com

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Intake Client Information

Has the patient attended counseling previously? (Consider other places than here): ☐Yes ☐No

If yes, with whom? **Approximate Dates:**

1. _____ _____
2. _____ _____
3. _____ _____

Issue(s) addressed, and which were resolved?

_____
_____
_____
_____

What are you looking to accomplish, change, or improve through the counseling process?

_____
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Release of Information - Primary Care Physician (PCP)

Client Name: _____ Date of Birth: _____

I, _____, authorize Counselors Associates Ltd and all its employees to release and to receive health record information for the Client named above to the following Primary Care Physician:

Primary Care Physician Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Telephone Number: _____ Fax Number: _____

Information shall consist of duplicate records and/or verbal consultation concerning treatment and/or education. Please check all the forms of documents you would like to release:

- ☐ Clinical Records (All)
- ☐ Educational Evaluation
- ☐ Social History
- ☐ PCP Contract Form
- ☐ Psychiatric Evaluation
- ☐ Intake Summary
- ☐ Psychological Evaluation
- ☐ Medical History
- ☐ Discharge Summary
- ☐ Treatment Plan
- ☐ Mental Health Info
- ☐ Other: _____

The information is needed for the purpose of adopting a more comprehensive and integrated approach to the client's health care and maintaining continuity of care for this purpose only unless otherwise permitted or required by law. This authorization may be revoked at any time by the client. Revoking of this authorization shall not cancel any prior action that has already transpired. This authorization is terminated one year from the date of signature below. A photocopy, facsimile or duplicate copy of this authorization shall be as valid as the original. The person signing this consent has a right to receive a copy of it. My signature indicates I have received a copy of this authorization to release medical records.

☐ **I do** give my mental health provider permission to have contact with the above listed Person or Company.

☐ **I do not** give my mental health provider permission to have contact with the above listed Person or Company.

Client (12 and over must sign): _____ **Signature Date:** _____

Guardian Signature: _____ **Signature Date:** _____

**PRIVACY ACT STATEMENT
1. The authority for soliciting the information comes from 10 USC 3012 2. The purpose for soliciting the information is to provide the therapist/counselor data to assist in counseling you are seeking. 3. The information will be maintained under strict professional guidelines and until, by law, your records are released to be destroyed. 4. Providing the information is voluntary. There will be no adverse effect on you for not furnishing the information other than that certain data might not otherwise be available to the counselor/therapist to enable him/her to provide you the most effective therapy.

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Release of Information – Person, Company, or Entity

(* Must fill out one form for each person, company, or entity ***)**

Client Name: _____ Date of Birth: _____

I, _____, authorize Counselors Associates Ltd and all its employees to release and to receive health record information for the Client named above to the following person, company, or entity:

Person, Company, or Entity: _____

Address: _____

City: _____ State: _____ Zip code: _____

Telephone Number: _____ Fax Number: _____

Information shall consist of duplicate records and/or verbal consultation concerning treatment and/or education. Please check all the forms of documents you would like to release:

- ☐ Clinical Records (All)
- ☐ Educational Evaluation
- ☐ Social History
- ☐ PCP Contract Form
- ☐ Psychiatric Evaluation
- ☐ Intake Summary
- ☐ Psychological Evaluation
- ☐ Medical History
- ☐ Discharge Summary
- ☐ Treatment Plan
- ☐ Mental Health Info
- ☐ Other: _____

The information is needed for the purpose of adopting a more comprehensive and integrated approach to the client's health care and maintaining continuity of care for this purpose only unless otherwise permitted or required by law. This authorization may be revoked at any time by the client. Revoking of this authorization shall not cancel any prior action that has already transpired. This authorization is terminated one year from the date of signature below. A photocopy, facsimile or duplicate copy of this authorization shall be as valid as the original. The person signing this consent has a right to receive a copy of it. My signature indicates I have received a copy of this authorization to release medical records.

☐ **I do** give my mental health provider permission to have contact with the above listed Person or Company.

☐ **I do not** give my mental health provider permission to have contact with the above listed Person or Company.

Client (12 and over must sign): _____ **Signature Date:** _____

Guardian Signature: _____ **Signature Date:** _____

**PRIVACY ACT STATEMENT
1. The authority for soliciting the information comes from 10 USC 3012 2. The purpose for soliciting the information is to provide the therapist/counselor data to assist in counseling you are seeking. 3. The information will be maintained under strict professional guidelines and until, by law, your records are released to be destroyed. 4. Providing the information is voluntary. There will be no adverse effect on you for not furnishing the information other than that certain data might not otherwise be available to the counselor/therapist to enable him/her to provide you the most effective therapy.

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Consent to Treatment

Welcome to Counselors Associates Ltd. We are honored you chose us to help you with your concern today.

Before beginning therapy, it is important you understand the following points:

1. While you should expect benefits from therapy, outcomes cannot be guaranteed.
2. Therapy may cause emotional strains and you may feel worse during your course of therapy because making life changes can be distressing.
3. Counselors Associates Ltd does not provide emergency services. If there is an emergency, please call 911, or go to your local emergency room. You agree to follow up with Counselors Associates Ltd after the immediate crisis is resolved so that we may update and plan for continuity of care.
4. Regardless of insurance pre-certification or authorization for services rendered, you are responsible for the total balance on your account.
5. The decision to receive services is strictly voluntary, even though an insurance company or physician may have referred you.
6. Confidentiality is of the utmost importance to our office. It is important you understand the limits of confidentiality. Counselors Associates Ltd therapists are required to disclose information about you if one or more of the following conditions apply:
    a. You are a danger to yourself or others.
    b. You seek treatment to avoid detection or apprehension.
    c. Your therapist was appointed by the court to evaluate you or determine your competence.
    d. You are under the age of 16 and are a victim of a crime.
    e. You are the victim or perpetrator of child abuse or elder abuse.
    f. You die and information is required regarding a will or deed.
    g. You file a lawsuit against Counselors Associates Ltd, any of its therapists and employees.
    h. If Counselors Associates Ltd, any of its therapists and employees file a lawsuit against you.
    i. You claim mental damages in a lawsuit.
    j. You waive your rights or give consent.
    k. Your insurance company is paying for services and decides to review your records.
    l. Counselors Associates Ltd and/or any of its therapists and employees receives a subpoena and is required by law to yield information.

Client Rights and Responsibilities

1. To ask any questions regarding your treatment.
2. To end therapy at any time.
3. To receive respectful treatment that will be helpful and to be treated with dignity.
4. To have a safe environment.
5. To ask for what you want and need.
6. To work together to develop the most helpful treatment plan possible for you.

I consent to treatment by Counselors Associates Ltd and I consent to Counselors Associates Ltd to share necessary health information with staff hired or contracted to assist with billing, scheduling, or other office operations.

Patient Name: _____ **Date:** _____

Patient Signature: _____ **Guardian Signature:** _____

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Contract/Financial Agreement

Counselors Associates Ltd is a private practice where therapists engage in the practice of mental and behavioral health services through the delivery of psychotherapy, psychiatric medication management, and counseling. Some therapists are licensed to practice independently, and others require supervision. Those who require supervision may work under the direction and supervision of a fully credentialed practitioner. Your contract for services is with Counselors Associates Ltd, not the individual therapist.

Client agrees to allow the therapist to be assisted by a co-therapist, student Intern, or supervisor if either or both deems it appropriate. Note on Privacy: I understand the counseling sessions in which I participate with a co-therapist or supervisor are for the purpose of improving my care, and not an invasion of my rights of privacy; therefore, in consideration of the benefits received by me, I specifically waive my rights of privacy for this purpose only.

Rights and Risks: Please feel free to ask questions about any aspect of the counseling process. You need to be willing to discuss what troubles you and be open to change. You may remember unpleasant events, arouse intense emotions, and/or alter close relationships. The purpose of counseling is to facilitate your process. If you have been referred by a court or state agency, you have the right to divulge only what you want included in a report.

Clients, ages 12-17:

- Have the right disclose their information as specified under Illinois Law.
- Parents/Guardians of clients, ages 12-17, can receive information regarding current physical and mental condition, diagnosis, treatment needs, services provided, and services needed.
- Per Illinois law, all other information will be released at the discretion of the client, unless the therapist deems it medically necessary.
- Copies of this records release law are available upon request.

All office visits are by appointment only.

Go paperless!
By providing your email address and signature on the signature page of the Contract/Financial Agreement you authorize Counselors Associates Ltd to issue you invoices and statements via email. You may withdraw your consent at any time by providing a request in writing via email or paper.

Email Address: _____

• Phone: 618-972-1568 • Billing: 618-972-2866 • Fax: 618-205-3561
• Contact Email: info@counselorsassociates.com • www.counselorsassociates.com

Contract/Financial Agreement

Billing and Insurance:

- All copays and session fees are due at the time of service unless a payment plan has been previously arranged.
- Returned checks will incur a minimum fee of $35, plus the original amount of the check.
- If fees are not paid at the time of service, we reserve the right to reschedule your appointment.
- Except in the case of minors, or when other arrangements are made, the person receiving the counseling service is financially liable. Clients are responsible for payment and insurance claims on their accounts.
- The parent who calls to make the appointment for a minor is responsible for any bills, unless otherwise stated in custody documents.
- If the client experiences a change to their insurance or financial situation, you must contact the billing department to update the information. You may find the phone number and our web site address at the bottom of page.
- If the client's policy requires preauthorization to receive services, this is their responsibility, and needs to be handled prior to their first visit.
- The Insurance Verification Form must be on file before we can bill the client's insurance company.
- Clients will receive a statement monthly reflecting any balance due on their account.
- Clients will be provided an "insurance ready" receipt upon request. Also known as a "Superbill".
- Counselors Associates Ltd will not accept responsibility for collecting insurance claims or for negotiating a settlement on a disputed claim.

Failure to pay your part may jeopardize your benefits. Copays and Session Fees are not negotiable.
Accounts become delinquent after thirty (30) days. Delinquent accounts may be turned over for collection.

Most common approximate fees incurred for counseling. This is not an exhaustive list:

Intake session(s)	$210.00
Average therapy session	$190.00
Brief therapy session	$175.00
Family Therapy	$200.00
No show or late cancellation	$100.00
Phone call to therapist / 10 minutes	$50.00
Legal activities / 45 minutes	$500.00+
Appointments after 6pm or on weekend	$20 (in addition to normal fee)

**Note: Phone calls over 5 minutes are billed in 10-minute increments.

I understand and accept that I will be charged a $100 fee if I miss a scheduled appointment or cancel an appointment with less than 24 hours' notice. If unable to reach our office staff via phone, an email or voicemail indicating the patient's name and the appointment date/time must be received by Counselors Associates Ltd 24 hours prior to the appointment.

Patient Name: _____ **Date:** _____

Patient Signature: _____ **Guardian Signature:** _____

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Contract/Financial Agreement

Credit Card information:

Card Type: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Card Number: ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___

Expiration Date: ___ ___ / ___ ___ CVV (3 or 4 digits): _____

Name on the card: _____

Billing Address Line 1: _____

Billing Address Line 2: _____

Billing City: _____

Billing State: _____ Billing Zip Code: _____

Card Owner's email address: _____

This card will be charged for the full amount of your bill if 3 or more attempts have been made by our offices to contact you to pay an outstanding balance.

☐ I authorize Counselors Associates Ltd to charge my card automatically after the insurance processing or private pay processing has completed for each visit by initialing at the front of this statement.

Card Owner's Signature: _____ **Signature Date:** _____

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Insurance Verification

This form determines how your account is billed. You may choose to bill your insurance, if accepted, or as a Private Pay client. The decision may be updated at any time by completing a new Insurance Verification form. Choosing to bill for counseling services through your insurance carrier is an important decision you must make. Please keep in mind, if you choose insurance benefits, the insurance company will have access to your records. According to federal regulations, you may choose to pay out-of-pocket and not bill through your insurance policy. Clients who choose to pay out-of-pocket are considered Private Pay clients. As a Private Pay client, Counselors Associates Ltd would not have the authorization to share your records with your insurance company. Please note that the rates you pay for services as a Private Pay client may be higher than the rates you would pay through your insurance company.

If you choose to be a Private Pay client and have agreed to pay the current Private Pay session rate for your clinician and you have attended sessions those sessions remain Private Pay. You cannot bill your insurance company for the past sessions since they have already been designated as Private Pay. The converse is true as well. If you choose to have Counselors Associates Ltd file claims with your insurance and later decide to switch to be a Private Pay client, the past sessions will not be able to be changed to private pay and the insurance company will have access to the records for the sessions submitted to the insurance company.

Knowing your out-of-pocket expenses prior to receiving services is your right and your sole responsibility.

Select one box:

☐ I choose to be designated as a Private Pay client at Counselors Associates Ltd. I will pay for sessions out-of-pocket with cash, check, or credit card, in accordance with my signed contract for services. I do not authorize Counselors Associates Ltd, its agents or employees, to share my private information with my insurance company.

☐ I would like to seek payment for services through my insurance company. I understand if Counselors Associates Ltd is in network with my insurance company, my rates may be discounted according to their contract with my insurance company. I understand if Counselors Associates Ltd is out of network with my insurance company, I will be responsible for any copays, coinsurance amounts, deductible payments, or any portion of the session fees not covered by my insurance plan. Furthermore, I understand in the event of insurance non-payment, I will bear the cost of collection. I accept responsibility to keep track of insurance company parameters by monitoring the allowed number of visits, if applicable. I grant this permission to be effective as of the date of my signature and witnessed by a representative of Counselors Associates Ltd. I authorize Counselors Associates Ltd and my clinician to release to my insurance company any information acquired in the course of my therapy.

Client Name Printed: _____ **Date of Birth:** _____

Client Signature: _____ **Signature Date:** _____

Guardian Signature: _____ **Signature Date:** _____

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Notice of Privacy Practices Receipt and Acknowledgment of Notice

Client Name: _____ Date of Birth: _____

Please check the proper boxes and sign document.

☐ I hereby acknowledge I have received and/or have been given an opportunity to read a copy of Counselors Associates Ltd.'s Notice of Privacy Practices. I understand if I have any questions regarding the Notice or My Privacy Rights, I can contact Counselors Associates Ltd at 618-972-1568.

☐ Client refuses to acknowledge receipt of privacy practices.

Litigation Disclosure Agreement

If you are involved in litigation or become a party to litigation, you agree you will not call your Counselors Associates Ltd therapist to court to testify or release records of service. Our goal is to provide treatment to meet the mental health needs of our clients and to maintain and to protect their right to confidentiality.

Our role as clinicians is to provide treatment and not to make recommendations to courts in legal matters. It is our policy not to testify in court cases because experience has shown that the professional relationship is often harmed when counselors testify.

In domestic litigations, such as divorce and custody disputes, courts can appoint professionals who have had no prior contact with a family to conduct custody evaluations and to make recommendations to the court. It is unethical for clinicians providing treatment to children or family members to make recommendations for judges in domestic litigation or to write letters of support to courts containing custodial or parenting recommendations.

By signing this form and consenting to treatment, you agree not to call Counselors Associates Ltd therapists as a witness in litigation matters. Additionally, you agree not to request any letters of support or therapeutic notes to judges or attorneys.

Client Signature: _____ **Signature Date:** _____

Guardian Signature: _____ **Signature Date:** _____

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Informed Consent for Telehealth Services

Definition of Telehealth: Telehealth involves the use of electronic communications to enable Counselors Associates Ltd clinicians to connect with individuals using live interactive video and audio communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data. I understand that I have the rights with respect to telehealth:

- The laws that protect the confidentiality of my personal information that I have already signed or will sign also applies to telehealth. A copy of our Office Policies and Therapeutic Informed Consent can be provided.
- The right to withhold or withdraw my consent to the use of telehealth at any time during my care will not affect my right to future care or treatment.
- The use of telehealth with Counselors Associates Ltd is due to directives by the WHO, CDC, and IL Governor to reduce social contact and this agreement will extend as recommendations extend.
- By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. **If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.**

There are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. Our telehealth software utilizes secure, encrypted HIPAA compliant audio/video transmission software to deliver telehealth.

Payment for Telehealth Services: Counselors Associates Ltd will bill insurance for telehealth services. The standard copay and/or deductibles apply. If insurance does not cover telehealth, you may wish to pay out-of-pocket. We can provide you with a statement of service to submit to your insurance company.

Patient Consent to the Use of Telehealth: I have read and understand the information provided above regarding telehealth, have discussed the information with my counselor, and all my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained.

I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

Client Name Printed: _____ **Date of Birth:** _____

Client Signature: _____ **Signature Date:** _____

Guardian Signature: _____ **Signature Date:** _____

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• Contact Email: info@counselorsassociates.com • www.counselorsassociates.com

Informed Consent for Texting

Counselors Associates Ltd offers patients, parents, or guardians the opportunity to communicate by text messaging through our HIPAA compliant texting software to convey client information, and to discuss client conditions. Text message communication has several possible risks that patients, parents, or guardians should consider before using. The client, parent, or guardian should be aware when using the texting device that information could be seen by other people. **If the question or problem is urgent, and/or an immediate risk to the client, other action should be taken, such as calling 9-1-1 or the suicide prevention hotline number.**

Some of the possible risks of using text messaging include:

- Text messages can be sent on to other people, stored on a computer, or printed out on paper for storage.
- Text messages can be sent out and received by many recipients, some, or all of whom may be sent the text message accidentally.
- Text message senders can easily misaddress their message.
- Text message information is easier to change than handwritten or signed documents.
- Text message information may be kept on computers or electronic devices even after the sender or the recipient believes they deleted his or her copy.
- Text messages can occasionally be intercepted, changed, forwarded, or used without authorization or detection.
- Text messages can be used to introduce viruses into computer systems.
- Text messages can be used as evidence in court.

CONDITIONS FOR THE USE OF TEXT MESSAGING:
Counselors Associates Ltd will use reasonable means to protect the security and confidentiality of text message information sent and received. However, because of the risks outlined above, Counselors Associates Ltd cannot guarantee the security and confidentiality (privacy) of email/text messaging communication and will not be liable for improper use and/or disclosure of confidential information (including Protected Health Information that is the subject of the Federal Health Insurance Portability and Accountability Act of 1996). Thus, the client, parent, or guardian must consent to the use of text messaging for patient information.

CONSENT TO THE USE OF TEXT MESSAGING INCLUDES AGREEMENT WITH THE FOLLOWING CONDITIONS:
Counselors Associates Ltd may forward text messages internally to other staff or agents of Counselors Associates Ltd as necessary for treatment, reimbursement, and other operations. Counselors Associates Ltd will not, however, forward text messages to independent third parties who are not involved with the patient's treatment, reimbursement, or otherwise involved in their care, without the patient s prior written consent, except as authorized or required by law. Counselors Associates Ltd may possibly forward text messages to other health care providers participating in the patient s care.

The client, parent, or guardian should not use text messaging for medical emergencies or other matters that must be handled quickly. Text messages are used by Counselors Associates Ltd for appointment reminders or to share more generic information. When text messages are sent by a client, parent, or guardian, we will do our best to respond. You may reach out to our office by calling the Phone number found at the bottom of the page.

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• Contact Email: info@counselorsassociates.com • www.counselorsassociates.com

Informed Consent for Texting

The client, parent, or guardian is responsible for protecting their password or other means of access to text messaging. Counselors Associates Ltd is not liable for information that is read by other people through errors caused by the client or any third party.

If through text message communication, Counselors Associates Ltd determines that an office visit is necessary to address the problem, or if the client, parent, or guardian wants to have such a visit, it is the client's, parent's, or guardian's responsibility to schedule the appointment.

INSTRUCTIONS:
To communicate by text message, the client, parent, or guardian is advised to:

- Limit or avoid use of his/her employer's computer. Information is often stored on the employer's system and can be read by people within that organization.
- Inform Counselors Associates Ltd of changes in text messaging addresses.
- Review the text message to make sure it is clear, and that all needed information is provided before sending to Counselors Associates Ltd
- Understand that text messages from Counselors Associates Ltd will be encrypted.
- Confirm receipt of a text message from Counselors Associates Ltd, indicating it was received and arrived at the correct location.
- Take precautions to preserve the confidentiality of text messages, such as using screen savers and safeguarding computer passwords.
- Contact the Counselors Associates Ltd at office telephone number with any questions about using text messaging.

CLIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand the information Counselors Associates Ltd has provided me regarding the risks of using text messaging. I understand the risks associated with the communication of text messages between Counselors Associates Ltd and myself, and consent to the conditions outlined. In addition, I agree to the above instructions, as well as any other instructions that Counselors Associates Ltd may impose regarding e-mail or text message communications.

Preferred Phone Number to Text: _____

Client Name Printed: _____ **Date of Birth:** _____

Client Signature: _____ **Signature Date:** _____

Guardian Signature: _____ **Signature Date:** _____

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COVID-19 Informed Consent to Treatment

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Please initial each line).

_____ I understand in person sessions may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted.

_____ I understand that I am opting for elective sessions that may not be urgent or medically necessary, and that I have the option to have my sessions via Telehealth. However, while I understand the potential risks associated with receiving sessions during the COVID-19 pandemic, I agree to proceed with my desired sessions at this time.

_____ I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office.

_____ I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:

*Fever	*Dry Cough	*Sore Throat
*Shortness of Breath	*Runny Nose	*Loss of Taste or Smell

_____ I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled outside of the United States to countries that have been affected by COVID-19.

_____ I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with in person sessions. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through these elective sessions and give my express permission to you and the staff at your offices to proceed with providing care.

_____ I have been offered a copy of this consent form.

I KNOWINGLY AND WILLINGLY CONSENT TO IN PERSON THERAPY WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION. I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Client Name Printed: _____ **Date of Birth:** _____

Client Signature: _____ **Signature Date:** _____

Guardian Signature: _____ **Signature Date:** _____

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