PEDIATRIC PSYCHOLOGY ASSOCIATES

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

Patient First Name:_____ Patient Last Name:_____

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus," at any time or in any place. Our practice has taken steps to reduce the risk of exposure to the coronavirus within the office, details of which can be found on our website and in our offices. Please let us know if you have questions about our safety procedures.

We have reopened the office for in-person treatment for families where telehealth services are not indicated. Please note that we will continue to monitor reports from the CDC, WHO, and the State of Florida and we may choose to discontinue in-person services if health risks become too great. Should this become necessary, treatment via telehealth will be offered if it is deemed feasible and clinically appropriate. Additionally, if you decide at any time you would prefer to use telehealth services, please discuss this with your therapist in order to determine if that would be an appropriate option for your family.

At PPA we are committed to keeping all our families and staff safe. Visitors and staff/therapists that present with a fever or other COVID-19 symptoms, or anyone who may have been exposed to the coronavirus within the last two weeks, will not be permitted in the office and/or will be asked to leave PPA premises immediately.

Despite our careful attention to disinfection and use of personal safety barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your grocery store or other public spaces. We believe that our diligent efforts to prevent spread of the virus will make risk of exposure within our office minimal, but we must inform you that there is still risk, however slight.

Do you accept the risk of potential exposure and consent to in-person treatment?

Check one: Yes_____ No_____

Parent/Patient E-Signature:_____ Date:_____