MATHERS RECOVERY

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

Patient Name: _____ **DOB:** _____
(please print)

Please read carefully and initial each selection below:

This document contains important information in regards to resuming in-person services in light of the COVID-19 public health crisis. Please read over this document carefully.

I understand that by signing this document I willingly consent to in-person treatment at Mathers Clinic/Mathers Recovery/ Mathers Community Mental Health Center practice during the COVID-19 pandemic.

DECISION TO MEET FACE-TO-FACE

I agree to meet in person for some or all future sessions with my provider(s). If there is a resurgence of the pandemic or if other health concerns arise I understand that it may be required for me to continue my treatment via Telehealth.

I understand that if at any time I would feel safer continuing, or returning to, Telehealth services, the practice will respect this 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 at that point in time.

RISKS OF OPTING FOR IN-PERSON SERVICES

I understand that by coming to the office, I assume the risk of exposure to the COVID-19 (or other public health risk). This risk may increase if you travel by public transportation, cab, or ride-sharing service.

PATIENT'S RESPONSIBILITY TO MINIMIZE YOUR EXPOSURE

In order to obtain services in person, I agree to take certain precautions which will help keep everyone and myself, safe from exposure, sickness, and possible death. If you do not adhere to these safeguards you may be asked to leave the office and we may require that your future services be provided via Telehealth only during the course of the pandemic.

I understand and agree to the following requirements of in-person services (Please initial all items):

_____ I will only keep my in-person appointment if I am symptom free.

_____ I will take my temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the COVID-19, you agree to cancel the appointment or proceed using Telehealth. (Please note: If you wish to cancel for this reason, the practice will not assess a cancellation fee.)

_____ I will wait in my car, outside, or in a designated safer waiting area until no earlier than 5 minutes before my appointment time.

_____ I will wash my hands or use alcohol-based hand sanitizer when I enter the building.

_____ I will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room.

(continued on next page.)

Mathers Recovery

Informed Consent for In-Person Services During COVID-19 Public Health Crisis (cont.)

_____ I will wear a mask in all areas of the office including my appointment session.

_____ I will keep a distance of 6 feet from others and ensure not make physical contact with others. (e.g. no shaking hands).

_____ I will try not to touch any part of my face with my hands, including my eyes. If I do so I understand I should immediately wash or sanitize my hands.

_____ If I bring a child, I will ensure that my child follows all of these sanitation and distancing protocols.

_____ I agree to take steps between appointments to minimize your exposure to COVID-19.

_____ I agree to immediately inform the practice if I have a job that exposes myself to other people who are infected with COVID-19.

_____ I agree to immediately inform the practice if a resident of my home tests positive for COVID-19, and agree to begin/resume treatment via Telehealth.

Practice Safety in the Event of Illness or Suspected Illness

Our practice is committed to keeping our patients, our staff, and our community safe from the spread of COVID- 19. If you show up to an appointment and the office staff believe that you may have a fever, present other symptoms, or believe you have been exposed to COVID-19, they will require that I leave the office immediately. We can follow up with services by Telehealth as appropriate.

Your Confidentiality in the Case of Infection

I understand that if I have tested positive for COVID-19, the practice may be required to notify local health authorities that I or my dependents may have been in the office. (Please note: 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 your visits.) By signing this form, I agree to this type of disclosure without signing an additional signed release to these agencies.

Informed Consent

This agreement supplements the general informed consent/business agreement that was agreed to at the start of working0 together.

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

Printed Name of Patient

Signature of Patient, Legal Guardian or Client Date

MATHERS RECOVERY

Elgin: 585 N Tollgate Rd, Ste E, Elgin, IL 60123 phone: 847.462.6099 fax: 847.628.6064
Fox Lake: 81 E Grand Ave, Fox Lake, IL 60020 phone: 224.908.3005 fax: 847.531.1296
Yorkville: 507 W Kendall Dr, Ste 1, Yorkville, IL 60560 phone: 224.760.7000 fax: 331.207.1921