



COVID-19 RISK INFORMED CONSENT

I, _____(client name) understand that I am opting to seek outpatient psychological services. I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact, and as a result, federal and state health agencies recommend social distancing. I recognize that all the staff at Hugh S. Smith, Ph.D. & Associates, P.C. are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with services.

I hereby acknowledge and assume the risk of becoming infected with COVID-19 should I proceed with services and give my express permission for Hugh S. Smith, Ph.D. & Associates, P.C. to proceed with the same. I understand that, even if I have been tested for COVID-19 and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID-19 after the test. I understand that, if I have a COVID-19 infection and even if I do not have any symptoms for the same, proceeding with the services can lead to a higher chance of complication and health risks.

I understand that possible exposure to COVID-19 before/during/after my session may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, intensive care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my psychological services, I may need additional care that may require me to go to an emergency room or a hospital. I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as risks for the treatment itself.

I have been given the option of telehealth or defer my services to a later date. However, I understand all potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my services.

INFORMED CONSENT FOR COVID-19 RISK. I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO IN-PERSON PSYCHOLOGICAL SERVICES.

Client Signature _____ Date _____