HUDSON VALLEY CENTER FOR COGNITIVE THERAPY
421 North Highland Avenue • Upper Nyack, NY 10960
(845) 353-3399 • Fax: (845) 353-2272 • http://www.hvcct.com

INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19

This document contains important information about our mutual decision to meet in-person 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 us.

Decision to Meet Face-to-Face
We have agreed to meet in person for some or all sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, we may need to use telehealth. You understand that, if I believe it is necessary, I may determine that we discontinue face to face meetings for everyone's well-being. If you decide at any time that you feel unsafe and would like to discontinue face to face meetings I will respect that decision as well.

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 or ridesharing.

Your Responsibility to Minimize Your COVID Exposure
To obtain services in person, you agree to take certain precautions which will help keep everyone safer from exposure. If you do not adhere to these safeguards, it may result in our discontinuing in-person sessions. Your signature below will indicate that you understand and agree to these actions:

1. You will only keep your in-person appointment if you are symptom free.
2. If you (or your child) test positive for COVID, you will immediately let me or Dr. Ziegler know.
3. If a resident of your home tests positive for COVID or if you had a known exposure, you will let me or Dr. Ziegler know.

We 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.

HVCCT Commitment to Minimize Exposure
Our practice has taken steps to reduce the risk of spreading the coronavirus within the office. 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 us all safe from the spread of this virus. If you arrive for an appointment and I believe that you have a fever or other symptoms or that you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth if appropriate.

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 is intended as a supplement to the general informed consent (the Client Information and Office Policy Statement) and does not amend any of the terms of that agreement.

Your signature below indicates agreement with its terms and conditions.

_____	_____	_____
Patient Signature	Printed Name	Date
_____	_____	_____
Parent or Guardian Signature (if under 18 years old)	Printed Name	Date
_____	_____	_____
Therapist Signature	Printed Name	Date