Steve Hoersting Psychological Services, PLLC

7000 Houston Road — Building 200 — Suite 21 — Florence, Kentucky 41042 Phone-
859-282-0180 Fax- 859-282-0862

PLEASE PRINT

DATE: _____

PATIENT INFORMATION

Name: _____ Gender: M - F – Other
DOB: ____/____/____ AGE: _____
ADDRESS: _____ CITY: _____STATE: _____ ZIP: _____
STUDENT - MARRIED - DIVORCED - WIDOW - OTHER EXPLAIN_____
PHONE: CELL_____HOME_____OFFICE_____
IS IT OK TO CALL YOU AT THE NUMBERS ABOVE: YES - NO
EMERGENCY CONTACT: _____PHONE: _____RELATIONSHIP:_____
EMAIL: _____IS IT OK TO EMAIL YOU AT THIS EMAIL? YES/NO
Who referred you: _____ Primary care physician: _____
What is the reason you are seeking treatment:_____

GUARDIAN INFORMATION

GUARDIAN NAME: _____ RELATIONSHIP TO PATIENT_____
DOB:____/____/____ AGE:_____ SS#_____ GENDER: M F OTHER
MARRIED - DIVORCED - WIDOW - OTHER EXPLAIN: _____
ADDRESS: _____CITY: _____STATE: _____ZIP: _____
PHONE: CELL_____HOME: _____OFFICE: _____
IS IT OK TO CALL YOU AT THE ABOVE PHONE NUMBERS? YES / NO ARE YOU EMPLOYED: YES / NO
EMPLOYER: _____
EMAIL: _____
IS IT OK TO EMAIL YOU AT THIS EMAIL: YES NO

RESPONSIBLE PARTY INFORMATION

NAME: _____ RELATIONSHIP TO PATIENT_____
DOB:____/____/____ AGE:_____ SS#_____ GENDER: M F OTHER
MARRIED - DIVORCED - WIDOW - OTHER EXPLAIN: _____
ADDRESS: _____CITY: _____STATE: _____ZIP: _____
PHONE: CELL_____HOME: _____OFFICE: _____
IS IT OK TO CALL YOU AT THE ABOVE PHONE NUMBERS? YES / NO ARE YOU EMPLOYED: YES / NO
EMPLOYER: _____
EMAIL: _____
IS IT OK TO EMAIL YOU AT THIS EMAIL: YES NO

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PLEASE PRINT

CHILD/ADOLESCENT CLIENT INFORMATION QUESTIONAIRE

CHILD'S NAME_____DOB____/____/_____

MOTHER'S NAME_____ FATHER'S NAME_____

MARITAL STATUS: SINGLE ____ MARRIED____ DIVORCED____ SEPARATED ____ WIDOWED ____

IF NOT MARRIED, CUSTODIAL AGREEMENT:

_____JOINT CUSTODY: W/JOINT LEGAL MEDICAL DECISION-MAKING W/ONE PARENT LEGAL MEDICAL DECISION-MAKING

_____ SOLE CUSTODY: W/JOINT LEGAL MEDICAL DECISION- MAKING W/ONE PARENT LEGAL MEDICAL DECISION-MAKING

IS THE PATIENT CURRENTLY, OR IN THE FORESEEABLE FUTURE, SUBJECT OF A CUSTODY/VISITATION ACTION? YES NO

**PLEASE INCLUDE A COPY OF ALL COURT/LEGAL DOCUMENTS FOR CUSTODY/ VISITATION/ AND DECISION MAKING ACTIONS*

LIST ANY HEALTH PROBLEMS FOR WHICH YOUR CHILD IS RECEIVING TREATMENT:

LIST CURRENT MEDICATIONS:

NAME	REASON FOR MEDICATION	DOSE	SIDE EFFECTS

BRIEFLY DESCRIBE WHY YOU ARE SEEKING TREATMENT IN OUR OFFICE:

LIST OTHERS IN THE HOME:

NAME	RELATIONSHIP TO CHILD	AGE	OCCUPATION

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Notice of Privacy Practices

Effective 12/01/2009

This notice describes how health information about you may be used and disclosed and how you get access to this information. Please review it carefully.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices and new terms of our notice effective for all health information we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available on request.

You may request a copy of our notice at any time. For more information about our privacy practices or for additional copies of this notice, please contact us.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other health care provider providing treatment to you with your consent.

Payment: We may use and disclose your health information to obtain payment for services provided to you with your consent.

Healthcare Operations: We may use and disclose your general health information (excluding personally identifying information) in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, and evaluating practitioner and provider performance. We may use or disclose your general health information (excluding personally identifying information) in order for us to review our services and to evaluate our staff performance. We may also use or disclose your health information to obtain a medical consultation regarding your care or treatment.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any other disclosures permitted by your authorization while it was in effect. We may also use or disclose your health information for any reason except those described in this notice.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you or someone in your home is a possible victim (or perpetrator) of abuse, neglect or domestic violence. We may disclose health information to appropriate authorities if we reasonably believe that you are a serious danger to yourself or others.

To Your Family and Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice. If you authorize release of information, we may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare.

Persons involved in your care: We may use or disclose health information to notify or assist in notification of a family member, or your personal representative or another person responsible for your care, or your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Required by law: We may use or disclose your health information when we are required to do so by law such as in legal response to valid judicial, administrative subpoenas or court orders.

When seeking psychological services, you have the right to expect that issues discussed during the course of individual therapy will be kept confidential. Confidentiality means that your personal/private information will not be shared with others, since psychologist/client communication is protected by law (privileged)

There are times however, when we believe that exchanging or receiving important information from others (e.g., doctors, teachers, etc.) allows us to better serve your psychological needs and provide a higher quality of care. Therefore, with your agreement, you may waive the privilege of confidentiality by providing your written permission on a Release of Information form. Once you sign a release form, you may withdraw your consent at any time. Please read the Notice of Privacy Practices guide provided to you.

Exceptions to confidentiality

There are several possible exceptions to confidentiality:

1. Danger to self and or others
    a. If there is a reason to believe that you are a serious danger to yourself or others your therapist must take steps to reduce the risk.

2. Insurance Reimbursement:
    a. If insurance reimbursement is arranged, insurance companies reserve right to have another professional review the case.
    b. Many insurers require periodic therapy summaries called outpatient treatment reports (OTR) before they will authorize additional treatment.
    c. Information included on the insurance claim form is no longer considered confidential.
3. Court Orders

a. There are cases where courts have ordered the release of otherwise privileged records, such as in certain child custody cases where judges have ruled that the well-being of the child outweighs the parent's privilege of confidentiality.
b. If you are involved in a criminal case, your records can be subpoenaed.

National Security: We may disclose to military authorities the health information of armed forces personnel under certain circumstances. We may disclose to authorized, federal officials' health information required for lawful intelligence, counterintelligence or other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of an inmate or patient under certain circumstances

Appointment reminders:

We may provide you with appointment reminders (such as voicemail messages, postcards or letters) unless you make a specific request to the contrary.

Patient Rights

Access: You have the right to view or obtain a copy of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. You may request that we provide copies in a format other than photocopies. We would use the format requested unless it is not practical for us to do so. We will respond to your request for access within 30 days of receiving the request. We reserve the right to charge you a reasonable cost-based fee for expenses such as photocopying and staff time after the first request for copies. We will charge $.20 per page and $25 an hour for staff time and postage if you want the copies to be mailed to you. If you prefer, we will prepare a summary or explanation of your health information for a fee. If we deny your request to review or obtain a copy of your health information you may submit a written request for a review of that decision. The person conducting the review will not be the person who denied your request. In some circumstances, our denial of your request to inspect and receive copies of your information is not subject to review.

Disclosure Accounting: You have the right to receive a record of disclosures made by us of your health information when you submit a written request. This record will not include disclosures made for treatment payment or health care operations; disclosures made directly to you; disclosures authorized y you pursuant to a

signed authorization or disclosures made for law enforcement purposes. You may request one such record at no charge every (12) months. The record requests must state the time desired and may not exceed six (6) years prior to the date of the request and may not include any dates prior to 12/01/09. The first disclosure record requests a 12-month period is free; additional requests will be provided for a fee. We will inform you of the fees before you incur any cost.

Restrictions: You have the right to request to place additional restrictions on our use and disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except when required by law or in an emergency).

Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. The request

must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternate the means or location of the request. We will make reasonable efforts to accommodate your request.

Amendment: You have the right to request that we correct your records if you believe information in your record is incorrect or important information is missing, by submitting a written request that provides the reason for requesting the amendment. We have the right to deny your request to amend the record if the information was not created by us; if it is not part of the health information maintained by us; if it is not part of the information which you would be permitted to inspect and copy; or if in our opinion the record is accurate;

Questions and Complaints: If you are concerned that we have violated your privacy rights, disagree with the decision made about access to your health information, you may contact (in writing) our Privacy Officer (listed below). You may also send a written complaint to the US Department of Health and Human Services Office of Civil Rights. We will provide you the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Privacy Officer:
Steve Hoersting, M.Ed., LPP, CBIA 7000 Houston Road, Bldg 200, Suite 21, Florence, Kentucky 41091 Phone (859)282-0180 Fax (859) 282-0862

ACKNOWLEDGEMENT FORM

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES. THE EFFECTIVE DATE OF THIS NOTICE IS 12/01/09.

Clients Name:_____ Date:_____

Signature of Client or Authorized Guardian_____ Date_____

Relationship of Authorized Guardian to Client_____

Steve Hoersting Psychological Services, PLLC
7000 Houston Road — Building 200 — Suite 21 — Florence, Kentucky 41042
Phone- 859-282-0180 Fax- 859-282-0862
PLEASE PRINT

OFFICE POLICY STATEMENT

AFTER READING EACH SECTION, INITIAL THAT you HAVE READ AND UNDERSTOOD THE INFORMATION. FEEL FREE TO ASK QUESTIONS IF SOMETHING IS NOT CLEAR AND DO NOT HESITATE TO RAISE ANY CONCERNS REGARDING THIS INFORMA TION WITH YOUR THERAPIST

_____ Confidentiality

When seeking psychological services, you have the right to expect that issues discussed during the course of individual therapy will be kept confidential. Confidentiality means that your personal/private information will not be shared with others, since psychologist/client communication is protected by law. (Privileged).

There are times however, when we believe that exchanging or receiving important information from others (e.g., doctors , teachers, etc.) allows us to better serve your psychological needs and provide a higher quality of care. Therefore, with your agreement, you may opt to share privileged information, filling out OUR RELEASE OF CONFIDENTIAL INFORMATION form. Once you sign the release form, you may withdraw your consent at any time. Please read the Notice of Privacy Practices guide provided you.

_____ Exceptions to Confidentiality

There are several possible exceptions to confidentiality:

Danger to self and/or to others

Insurance reimbursements:

If insurance reimbursement is arranged, insurance companies reserve the right to have another professional review the case.

Many insurers require periodic therapy summaries called outpatient treatment reports (OTR) before they will authorize additional treatment. Information included on the insurance claim form is no longer considered confidential.

Court Orders

There are cases where courts have ordered the release of otherwise privileged records, such as in child custody cases are judges have ruled that the well-being of the child out weights the parent's privilege of confidentiality.

If you are involved in a criminal case, your records can be subpoenaed.

_____ Appointments

Therapy appointments are typically scheduled for 40-45 minutes. You and your therapist will arrange the frequency of appointments that best suit your needs. Your insurance company may only allow for a specific number and frequency of appointments (e.g., every two weeks) Should you wish to make a change in the frequency of appointments please discuss it with your therapist.

_____ Missed appointments and cancellations

Since appointment times are held exclusively for you, late cancellations or missed appointment times are lost time which might have been utilized by someone else. For this reason, cancellations with less than 48 hrs prior notice or missed appointments will be billed directly to you at $80 per occurrence. Since insurance companies will not reimburse for lost time. Effective January 1, 2022 and due to increased demand for services in our office, if you do not show up for your first appointment without prior notice, you will NOT be rescheduled. If you are a current patient and do not show up twice for your appointment without prior notice, you will NOT be rescheduled and referred out to other sources in the area.

_____ COVID-19 disclosure

To continue services in person, you agree to take certain precaution which will help keep everyone (you, me, our staff, and other patients) safer from exposure, sickness, and possible death. Masks must be worn inside the office at all times. If you are feeling sick you MUST cancel your appointment OR change your appointment to a virtual visit. You must follow CDC guidelines of social distancing, hand washing, and sanitizing within our office space. There will be no physical contact between patient and staff. We reserve the right to refuse treatment to anyone who does not adhere to the safety protocols.

_____ INSURANCE COVERAGE

If you have health insurance, part of your expenses may be covered. Please call your insurance customer service by locating the customer service number located on the back of your insurance card prior to your appointment to verify services covered. We will submit Insurance claim forms for you. Effective June 1, 2017, we will no longer bill secondary Insurance companies. We will provide the documents necessary for the patient or guardian to file the secondary insurance if you wish to do so. Effective January 2020, we will no longer be accepting any insurance plans using a "third party administrator". This may include self- funded insurance plans and small business plans.

_____ NO SURPRISE ACT (NSA)

Beginning January 2022 we are ethically obligated to discuss out of pocket costs with patients upfront. This new requirement builds on that by adding more structure and specific time frames for action. Please see the NSA sheet in this packet for more information

_____ TESTING

Please note that not all types of testing are covered by medical insurance. Educational testing; ie; Dyslexia, Dysgraphia, Dyscalculia or non-verbal learning disorder are typically not considered medically necessary and therefore not considered eligible for reimbursement through your medical insurance plan. ADHD and ADD testing are both considered necessary and eligible under most plans. Out of pocket cost for learning disability testing will be discussed before any testing appointments are made.

_____ PAYMENTS

Effective June 1, 2017, we will no longer split payments for patient visits. We have been experiencing increasing complications due to parental disputes regarding the costs associated with treatment. * THE PARENT INITIATING TREATMENT AND BRINGING THE PATIENT IS FULLY RESPONSIBLE FOR THE COSTS OF TREATMENT. we will no longer bill any other non-insurance entity;(ie other parent) It will be up to the parent bringing the patient to obtain reimbursement from the other parent.

SIGNATURE SHEET

PERMISSION TO TREAT

I UNDERSTAND THE LIMITATIONS OF TREATMENT AND I AUTHORIZE STEVE HOERSTING, M.Ed. TO PROVIDE OUTPATIENT PSYCHOLOGICAL SERVICES FOR:AND I AM LEGALLY ABLE TO DO SO. (sole custody or married joint custody)

*SIGNATURE _____ Date _____

PRINTED NAME _____

Witness signature _____ Date _____

UNDERSTANDING OF OFFICE POLICY STATEMENTS

I have read the office policy statement and understand the contents. (If you have not received a copy, please ask for one)

*SIGNATURE _____ Date _____

PRINTED NAME _____

Witness signature _____ Date _____

UNDERSTANDING OF COVID-19 DISCLOSURE

I have read the covid-19 disclosure information and understand the safety protocols put in place (If you have not received a copy, please ask for one)

*SIGNATURE _____ Date _____

PRINTED NAME _____

Witness signature _____ Date _____

*ACKNOWLEDGEMENT OF RECEIVING NOTICE OF PRIVACY AND PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy of Practices. The effective date of the notice is 12/1/09. (If you have not received a copy, please ask for one)

*SIGNATURE _____ Date _____

PRINTED NAME _____

Witness signature _____ Date _____

*ACKNOWLEDGEMENT OF RECEIVING NOTICE OF NO SURPRISE ACT 2022

(If you have not received a copy, please ask for one)

*SIGNATURE _____ Date _____

PRINTED NAME _____

Witness signature _____ Date _____

Steve Hoersting Psychological Services, PLLC

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Phone 859-282-0180 Fax 859-282-0862

ACKNOWLEDGEMENT SUMMARY

Please initial the following statements

I acknowledge understanding of the following:

___I will be charged an $80 fee if I do not show up for my appointment or if I give less than a 48 hour notice.

___ If there is a co-payment , or protocol fee, It must be paid at time of service.

___Self Pay out of pocket charges must be paid before service is rendered

___There is a $15 charge for patient requested forms (FMLA, School forms including IEP, ALP, and 504 plans, OHI ect).

___There is a $25 charge for requested brief letters.

___Insurance is billed as a courtesy. I am responsible for the cost of services if the insurance company denies payment, I am responsible for fees of services provided.

___There will be a $35 returned check fee.

___There will be an additional 35% charged added to the balance of your bill if we are forced to send your account collections.

___ I will notify the office of termination of services.

Signature of responsible party_____ Date_____

Printed name_____Date_____

Witness_____Date_____

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41042 Phone- 859-282-0180 Fax- 859-282-0862
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NO SURPRISE ACT 2022

We are required by state law to provide a good faith estimate for items and services for uninsured and self- pay persons. Psychologists are ethically obligated to discuss fees with patients upfront. This new requirement builds on that by adding more structure and specific timeframes for action. We will inform all uninsured and self- pay patients that a good faith estimate of expected charges is available in a written document that is clear, understandable and prominently displayed; orally provided when the service is scheduled or when the patient asks about the costs; and available in accessible formats for patients. We will provide a good faith estimate of expected charges for a scheduled or requested service. That estimate will be provided within specified timeframes: If the service is scheduled at least three business days before the appointment date, but no later than business day and after the date of scheduling; If the service is scheduled at least 10 business days before the appointment date, no later than three business days after the date of scheduling; or if the uninsured or self-pay patient requests a good faith estimate (without scheduling the service,) no later than three business days after the date of the request. A new good faith estimate must be provided, within the specified timeframe, if the patient reschedules the requested item or service. If any information provided in the estimate changes, a new good faith estimate must be provided no later than 1 business day before the scheduled care. A good faith estimate is based on a notification of expected charges for a scheduled or requested service. The "expected charge" for a service is either the cash pay rate or rate established by the provider for an uninsured (or self- pay) patient, reflecting any discounts for such individuals; or the amount the provider would expect to charge if the provider intended to bill a health care plan directly for such service. The information provided in the good faith estimate is only an estimate, and the actual services or charges may differ from what is included in the good faith estimate. However, uninsured or self-pay individuals may challenge a bill from a provider through a new patient-provider dispute resolution process if the billed charges substantially exceed the expected charges in the good faith estimate of an amount that is at least $400 more than the expected charges listed on the good faith estimate for a specific provider.

Disclaimer: There may be additional items or services recommended as part of the course of care that must be scheduled or requested separately and are not reflected in the good faith estimate. The information in the good faith estimate is only an estimate and the actual services, or charges may differ from the good faith estimate. You have the right to initiate a patient- provider dispute resolution process if the actual billed charges substantially exceed the expected charges included in the good faith estimate. The initiation of a patient-provider dispute resolution will not adversely affect the quality of health care services furnished to the patient-The good faith estimate is not a contract and does not require the uninsured or self-pay individual to obtain the services from our office in the estimate. The Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for a service. The estimate is based on information known at the time the estimate was created. The Good Faith estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill. If you are billed for more than this Good Faith estimate, you have a right to dispute the bill. You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the US department of Health and Human Services (HHS) If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees

with you, you will have to pay the price on this Good Faith estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call them. Keep a copy of your Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

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Please read the following statements and sign the bottom to acknowledge our new INFORMED CONSENT FOR IN-PERSON SERVICES DURING THE COVID-19 PUBLIC HEALTH CRISIS PROTOCOL

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let us 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 future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that 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, so that is an issue we may also need to discuss.

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, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure
To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, [my other staff] and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Initial each to indicate that you understand and agree to these actions:

- You will only keep your in-person appointment if you are symptom free.
- You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, I won't charge you our normal cancellation fee.
- You will wait in your car or outside [or in a designated safer waiting area] until no earlier than 5 minutes before our appointment time.
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building.
- You will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room. For example, you won't move chairs or sit where we have signs asking you not to sit.
- You will wear a mask in all areas of the office (I [and my staff] will too).

- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me [or staff].
- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands.
- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols.
- You will take steps between appointments to minimize your exposure to COVID.
- If you have a job that exposes you to other people who are infected, you will immediately let me [and my staff] know.
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me [and my staff] know.
- If a resident of your home tests positive for the infection, you will immediately let me [and my staff] know and we will then [begin] resume treatment via telehealth.

I 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.

My Commitment to Minimize Exposure
My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in 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 you, me, [my staff] and all of our families safe from the spread of this virus. If you show up for an appointment and I [or my office staff] believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate. If I [or my staff] test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

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 supplements the general informed consent/business agreement that we agreed to at the start of our work together.

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

_____ _____
Patient/Client Date

_____ _____
Witness Date