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Informed Consent for In-Person Services During COVID-19 Public Health Crisis

This document contains important information about our decision (yours and Kelli Murdock Eickelberg, MA, CCC-SLP) to resume/begin in-person services considering the COVID-19 public health crisis.

Decision to Meet Face-to-Face

We have agreed to meet for in-person consultation, evaluation, or therapy services. If there is a resurgence of the pandemic, if the State of Oregon orders a shut-down of businesses or if other health concerns arise, Kelli Murdock Eickelberg, MA, CCC-SLP may require that we meet via telepractice. If either of us has concerns about meeting through telepractice, we will discuss this and try to address any apprehension together.

If you decide at any time that you would feel safer staying with or returning to telepractice services, I will respect that decision if it is feasible and clinically appropriate to deliver services via telepractice. Reimbursement for telepractice services may also be determined by your insurance company and applicable law, and payment for services is an issue you may need to discuss with your insurance carrier.

Risk of Opting for In-Person Services

You understand that by coming to the office, you and your child are assuming the risk of exposure to the coronavirus (or other public health risks). 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, Kelli Murdock Eickelberg, MA, CCC-SLP, our families and other patients served) safe from exposure, illness and possible death. If you do not adhere to these safeguards, it may result in our starting/returning to a telepractice arrangement. **Initial each line to indicate that you understand and agree to these actions:**

- You will only keep your child's appointment if you and everyone in your household is symptom-free.
  _____

- If anyone in your household is not feeling well or if you have other symptoms of the coronavirus, you agree to cancel the in-person appointment and we will conduct the session using telehealth if appropriate. If you wish to cancel for this reason, you will not be charged my normal cancellation fee. _____

- You and your child will wait in your car or outside until I come to get your child for their scheduled appointment. _____

- Upon entering my therapy suite, your child will cleanse their hands with hand sanitizer unless you or the person transporting your child agrees to assist that upon my arrival to the vehicle. If hand sanitizer is not tolerated, I will assist your child with hand washing in my office. _____

- Parents, or other persons transporting the child for treatment, are encouraged to wait in their vehicle during your child's session. Your child will be escorted back to the vehicle they arrived in at the end of the session. Parents, or the other person transporting your child, must be available to receive the child at least five minutes prior to the end of the session. _____

- If a resident in your home, or anyone with whom anyone in your family has had direct contact, tests positive for COVID-19, you will immediately notify Kelli Murdock Eickelberg, MA, CCC-SLP and we will resume treatment via telehealth if possible. _____

Kelli Murdock Eickelberg, MA, CCC-SLP's Commitment to Minimize Exposure

Kelli Murdock Eickelberg, MA, CCC-SLP agrees to maintain 6-feet distance in the office, when possible, use medical grade disinfectant on surfaces/objects touched between patients, wash hands between patients and will cancel/reschedule appointments if I experience any symptoms of COVID-19. Kelli Murdock Eickelberg, MA, CCC-SLP will also notify you immediately if I (or anyone in my immediate family) tests positive for the coronavirus so that you can take appropriate precautions.

Confidentiality in the Case of Infection

If you/your child has tested positive for the coronavirus I may be required to notify local health authorities that you have been in the office. If I must report this, I will only provide the minimum information necessary for their data collection and will not share any details about the reason for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE INFORMATION IN THIS DOCUMENT AND AGREE TO ABIDE BY ITS TERMS DURING OUR PROFESSIONAL RELATIONSHIP.

Signed _____ Date _____

Patient _____ Parent _____ Legal Guardian _____