Dr. Whitney Calhoun
Psychologist
(404) 491-1893

Midtown Psychotherapy Associates
INNOVATORS IN MENTAL HEALTH

199 Armour Drive Suite E Atlanta, GA 30324
367 Prince Avenue Suite G Athens, GA 30601

Psychological Assessment Background Information

Patient Name: _____ Date: _____

Age: _____Date of Birth: _____ Referred by: _____

Address: _____

City: _____ State: _____ Zip:_____

Preferred phone number: _____ Okay to leave a message? Yes OR No

Emergency Contact
Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone number: _____

Reason and/or Concerns to seek Psychological Assessment:

_____

_____

_____

Family Life

With whom does the patient reside (list all)? _____

List closest known family members/siblings and the relationship with each?

_____

_____

_____

Relationship Status: ___ Single ___ Married ___Divorced ___ Widow/Widower

___ Dating ___ Same-sex partner

(If applicable) How long have you been in the present relationship? _____

Does the patient have any children? Yes OR No

If yes, please list names and ages: _____

_____

Please indicate any significant family concerns the patient has experienced with a check mark.

___Death of a parent	___Time in juvenile detention center
___Separation from parent(s)	___Death of other significant family member
___Death of a sibling	___Death of a friend
___Separation from sibling(s)	___Death of a pet
___Death of a spouse/partner	___Divorce
___Separation from children	___Family mental health concerns
___Adoption/Time in foster care	___Job loss
___Physical; Emotional; Sexual Abuse	___Substance abuse (self or family member)
___Trauma	___Other:

Please explain any of the above areas:

_____

_____

_____

Birth and Developmental Milestones

Circle One:

Pregnancy: Full Term OR Premature If premature, explain: _____

Vaginal Birth OR Cesarian Section Birth Birth Weight: _____

To the best of your knowledge, during infancy was the patient:

Happy Baby Active Baby Quiet Baby Slow to Warm Baby Fussy Baby

Further explain, if desired: _____

Please report any birth complications (ex: oxygen levels; birth defects; developmental concerns; NICU; other birth related information):

_____

_____

_____

To the best of your knowledge, when did the following occur:

Sit independently: _____ Use Words: _____

Crawl: _____ Use Two Word Phrases: _____

Walk: _____ Unknown, but Normal Development: _____

Potty Trained: _____

Please describe any childhood developmental concerns or areas that may have impacted the patient:

_____

_____

Did the patient receive an early intervention before the age of 3?

_____

_____

Medical and Mental Health History

Has the patient ever been diagnosed or treated for any **major medical** problems: Yes OR No
Please explain:

_____

_____

Has the patient ever been diagnosed or treated for any **mental health concerns** problems (ADHD, autism, anxiety, depression, hallucinations; suicidal/homicidal behavior):
Yes OR No
Please explain, including diagnosis, treatment, and/or medications:

_____

_____

Please list any prior treatment the patient has received for mental health concerns:

Name of Provider	Areas Addressed	Dates of Treatment

Is the patient currently taking any medications? Yes OR No

Has the patient experienced a head injury? Yes OR No

Has the patient ever been hospitalized for any medical or mental health reason? Yes OR No

If yes, please list the date and the reason for hospitalization. Please include hospitalizations due to mental illness, illness, injury, or surgery.

_____

_____

_____

_____

If yes, please list current medication name and dosage.

_____

_____

Does the patient have a history of disordered eating, anorexia, bulimia, or ARFID? Yes OR No

Is the patient currently on a diet? Yes OR No

If yes, please describe. _____

_____

Have any relatives ever been treated for a mental health condition or substance abuse problems?

If yes, please list their relation to the patient and condition treated.

_____

_____

Student/Occupational Life

At what age did the patient begin preschool/school: _____

Has the patient been retained in any grade? _____

Any educational concerns around the patient's academic performance? _____

While attending school, any special serveries:

Speech Therapy: _____ Occupational Therapy: _____

Remedial Reading: _____ Physical Therapy: _____

Counseling: _____

Please describe academic areas of strengths and weaknesses: _____

Highest Level of Education: _____

Last School Attended/Major: _____

Please list all schools attended (preschool; primary; middle; high school; secondary; graduate):

_____

_____

_____

Occupation (if applicable):

Current job title: _____ Hrs/week: _____

Employer name: _____

Address:_____

City: _____ State: _____ Zip:_____

Social/Emotional History

As a child, did an adult ever hit, kick, burn or beat the patient? Yes OR No

As a child, did an adult ever berate, yell at, or overly criticize the patient? Yes OR No

As a child, did anyone ever sexually touch the patient without consent? Yes OR No

As a child, did anyone ever force the patient to have sex? Yes OR No

As an adult, has a romantic partner ever hit, kicked, burned or beat the patient? Yes OR No

As an adult, has anyone ever sexually touched the patient without consent? Yes OR No

As an adult, has anyone ever forced or coerced the patient into having sex? Yes OR No

What three words best encapsulate the patient:

_____

To the best of your knowledge, how would you describe the patient:

_____

_____

Please describe the patient's relationship with peers and social engagements (i.e., friendship; social support; activities; clubs; sports teams; religious involvement; etc.):

_____

_____

_____

Please describe any significant behavioral concerns of the patient (i.e., lying; stealing; aggression; etc.):

_____

_____

_____

Please share an experience that the patient might consider traumatic (also may share directly with Dr. Calhoun, if desired):

_____

_____

Substance Abuse

Please indicate any substance use below:

Substance	Yes/No	How often?	How much?	Last use
Alcohol				
Caffeine				
Nicotine				
Marijuana				
Cocaine				
Heroin				

LSD				
Narcotics				
Other:				

Please list the ages at which the patient first tried alcohol and/or other substances.

Is substance use a current concern? Yes OR No

As a child, did either of the patient's parents have a problem with alcohol? Yes OR No

As a child, did either of the patient's parents take illegal drugs? Yes OR No

Legal Concerns

Does the patient have any historic legal involvement? Yes OR N0

If yes, please describe (i.e., divorce, custody, criminal charges, etc.)

Does the patient currently have any legal involvement? Yes OR NO

If yes, please describe (i.e., divorce, custody, criminal charges, etc.)

Other

Please list your hobbies/leisure activities:

What coping skills help the patient relax or calm down?

Please describe anything else that you would like Dr. Calhoun to know:

Please describe any further concerns that may impact the patient:

School/Work:	Social:
Emotional:	Appetite:
Sleeping:	Urine/Fecal Accidents:

Other:

End Background Information

Please return to Dr. Calhoun or email to Dr.WhitneyCalhoun@gmail.com

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Psychological Assessment Informed Consent

General Information: Thank you for choosing me as your mental health provider. I want to be certain that you understand what to expect during your evaluation. This consent will provide a clear framework for our work together. A psychoeducational evaluation typically involves a clinical interview, and an assessment of intellectual functioning, processing skills, academic functioning, memory, executive functioning, and social-emotional functioning. Background history, as well as previous records, provide additional information to assist in the evaluation.

Fees:
I am an out-of-network provider. This means that I am not a member of a provider network for any managed care plans. Your insurance plan may or may not cover visits to an out-of-network provider.

You (not your insurance company) are responsible for full payment of the service rate. It is very important that you find out exactly what mental health services your insurance policy covers. I do not provide billing directly to insurance companies. Further information regarding fees is located in the Psychological Assessment Financial agreement and Credit Card Authorization Form.

Cancellation Policy: If you must cancel an appointment, please give a minimum of 24 hours advance notice. If this minimum is not provided, you will be charged a cancellation fee of $300. Given the large amount of reserved time made available to you for testing appointments, short notice cancellations for the testing sessions may result in the cancellation of subsequent appointments.

Psychological Testing: Psychological evaluation is a process that includes a combination of clinical interview, completion of written questionnaires, and use of a variety of standardized measures in one or more one-on-one appointments with the patient. Depending upon the individual concerns and questions to be answered by the evaluation, testing may include measures of:
• Cognitive Ability
• Academic Achievement and Learning Progress
• Attention and Executive Functioning
• Visual and Auditory Information Processing
• Problem Solving Strategies
• Motor and Visual Perceptual Abilities

• Memory
• Behavioral and Emotional Functioning

What to expect:
Testing Day: The first appointment will include a clinical interview with requested parties and multiple hours of testing in a variety of the above areas. Depending on the needs of the patient, the testing day can be completed in one day or broken up into two days.

Feedback Meeting: The feedback meeting will be held within 4- 6 weeks after the initial testing day and will include requested parties. Following clarification during the feedback meeting, the compressive report will be available for pick up or mailed to a given location.

Use of the Evaluation Report: After the written report has been prepared and shared, the usual next step is to share the report with other involved professionals including but not limited to the school team, the pediatrician, and other medical professionals. On many occasions, parents set up a meeting at the school to go over the recommendations and determine if additional supports can be put in place. Please be aware that it is not in my control whether the school will agree to implement the recommendations. The recommendations will be practical, driven by the test data and relevant to the needs of your child in the context of the evaluation results.

While I stay up to date on the rules for provision of accommodations for standardized testing and the types of test instruments recommended for consideration for accommodations, I do not have any special power to obtain approval for accommodations for standardized testing such as the ACT, SAT or AP tests. I want you to know in advance that I will not change the presentation of the results, the diagnoses or the recommendations purely so that they meet criteria for special supports or accommodations; to do so would be unethical. All reasonable changes to the report must be finalized with 60 days of the Feedback Meeting. Any further agreed upon revisions occur with a $250 an hour charge.

Confidentiality: The evaluation content and all relevant materials will be held confidential unless you request in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If you threaten or attempt to commit suicide or otherwise conduct yourself in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If you threaten grave bodily harm or death to another person.
3. If I have a reasonable suspicion that you or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and #4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If you are being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

8. If you seek insurance reimbursement, I am required to provide a clinical diagnosis. I may be required to provide a copy of the psychological evaluation report. This information will become part of the insurance company files. I have no control over what insurance companies do with this information once it is in their possession. By signing this form, you agree that I can provide requested information to your insurance company.

Consultation: Occasionally, I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Pertinent information about you may be shared in this context without using identifying information.

Emergency Procedure: The best way to reach me is through the confidential voice mail answering system. Please be aware that I do not answer calls when I am in appointments, but I check voice mail often. I will make every effort to return your call within 24 – 48 hours, except for weekends and holidays, but cannot guarantee that this is always possible. If you are not able to reach me and feel that your child is having an acute mental health emergency and you cannot wait for a return call, please contact you or your child's medical provider or go to the nearest emergency room

Special Circumstances: I provide consultation, psychological evaluation, and psychotherapy services to assist with problem resolution and do not specialize in evaluations to be used in legal proceedings, such as for forensic issues or court proceedings for custody determination. If you anticipate that this is needed, I will refer you to professionals who have this area of specialization in their practice. Although very unlikely, it is important that I share the following information in advance: In the event that I am required by subpoena or court order to testify in any matter related to the psychological evaluation services, you will be expected to pay for all of the professional time used, including preparation and transportation costs, even if I am called to testify by another party. If I am subpoenaed by another party in litigation with you and you do not wish the subpoena answered, it is your responsibility to contract with your lawyer to quash the subpoena or to sign a waiver of confidentiality.

Because of the substantial difficulty of managing such legal involvement while maintaining scheduled appointments in my practice at the same time, the fees are $ 350 per hour for preparation and attendance at any legal proceeding.

Your signature below indicates that you have read the information in this agreement and agree to abide by its terms during our professional relationship. By your signature below, you indicate that:

- You have been informed of and understand the type of services to be provided.
- You have been informed of the limits of confidentiality.
- You understand and agree to the payment and cancellation policies.
- You accept full responsibility for all fees incurred in completing the psychological evaluation as spelled out in the agreement.
- You understand that, if you are provided with a digital copy of the report, you are not permitted to make any changes to the report.

I acknowledge and agree to these terms and conditions.

_____ _____

Printed Name of Patient Date

_____ _____

Signature of Patient Date

If Applicable:

_____ _____

Signature of Legal Guardian One/Relationship Date

_____ _____

Signature of Legal Guardian Two/ Relationship Date

_____

End of Form

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PSYCHOLOGICAL ASSESSMENT FINANCIAL AGREEMENT
CREDIT CARD AUTHORIZATION FORM

Psychological Testing: Psychological testing can provide valuable information about the way a person thinks, learns and copes. It is a critical part of the process of accurately diagnosing learning disabilities and attention problems, as well as a way of better understanding an individual's intellectual, behavioral, and social-emotional development.

Fees: The fee for a psychoeducational evaluation is $2,500. An evaluation includes a clinical interview, 6-8 hours of testing, a 1-1.5 hour feedback session, and a comprehensive report provided within 4-6 weeks of the feedback session. Upon request, the evaluation also includes up to three 20-minute phone consultations to gather collateral information. There is a $100 fee for each additional requested consultation. I will make three attempts to schedule the consultations between the first testing session and when I submit the final report to you. After that, the rate to complete a consultation and amend the report to include a summary is $100/hour. A limited number of exceptions to the above rates may be made in the case of extenuating circumstances. I am happy to make minor revisions to the report up to two-weeks after I submit the report to you at no additional cost.

Cash, checks and credit cards will be accepted as forms of payment. Checks are made payable to Virginia Highland Psychology, LLC. You will be provided a "superbill" at the time of service serving as record and receipt for all charges. This should be used to submit for reimbursement from your insurance company. You are responsible for contacting your insurance company regarding the rate of reimbursement, if any, prior to entering this contract for services. Please note that there is a $25 fee for returned checks. Should you miss a payment, sessions may be postponed until the full payment is rendered. You are responsible for the full payment at the time service is provided.

All clients are required to provide a credit card number to keep on file in the case of missed appointments or late cancellations. This information is kept on our confidential EHR (Theranest), which is in accordance with HIPAA guidelines. If you "no show" or cancel your appointment without 24-hour or more notice, there is a $300 fee be charged to your card. Please note that insurance companies do not reimburse for missed appointments.

Please provide the requested information below:

I hereby authorize Dr. Whitney Calhoun (dba Virginia Highland Psychology LLC) to charge my credit card as follows:

Card type: MC Visa Discover AMEX HSA

Name on Card: _____

Credit Card Number: _____

Exp. Date: _____

CV code: _____

Address with Card: _____

_____

I have read, understand and agree to the above fee payment and credit card policy for service provided by Dr. Whitney Calhoun (dba Virginia Highland Psychology LLC).

_____
Client Name

_____ _____
Client Signature Date of Signature

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NOTICE OF POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations"
    - Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another healthcare provider, such as your family physician or another psychologist/social worker.
    - Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
    - Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within my practice group, such as sharing, employing, applying,

utilizing, examining, and analyzing information that identifies you.

- "Disclosure" applies to activities outside of my practice group, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization via a Release of Information from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that

Initials _____

authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse**: If I have reason to believe that a child has been subjected to incest, molestation, sexual exploitation, sexual abuse, physical abuse, or neglect, or I observe a child being subjected to conditions or circumstances which would reasonably result in sexual abuse, physical abuse, or neglect, I must notify Child Protective Services.
- **Adult and Domestic Abuse:** If I have reason to believe that a vulnerable adult (defined below) is suffering from abuse, neglect, abandonment or exploitation, I am required by law to make a report to Adult Protective Services as soon as I become aware of the situation. A "vulnerable adult" means an elder adult, or an adult who has a mental or physical impairment which substantially affects his or her ability to: (a) provide personal protection; (b)provide necessities such as food, shelter, clothing, or mental or other health care; (c) obtain services necessary for health, safety, or welfare; (d) carry out the activities of daily living; (e) manage his or her own resources; or (f) comprehend the nature and consequences of remaining in a situation of abuse, neglect, abandonment or exploitation.
- **Health Oversight:** If you file a complaint against me with the Utah Division of Occupational and Professional Licensing, I may disclose to them information from your records relevant to the complaint.
- **Judicial or administrative proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without written authorization from you or your personal or legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I will inform you in advance if this is the case.
- **Serious Threat to Health or Safety**: If you communicate to me an explicit threat to kill or inflict serious bodily injury upon a reasonably identifiable person, including yourself, and you have the apparent intent and ability to carry out that threat, I have the legal duty to take reasonable precautions. These precautions may include disclosing relevant information from your mental health records which are essential to protect the rights and safety of others and yourself. I also have such a duty if you have a history of physical violence of which I am aware and I have reason to believe there is a clear and imminent danger that you will attempt to kill or inflict serious bodily injury upon a reasonably identifiable person.

IV. Patient's Rights and Provider's Duties:

Patient's Rights:

- **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- **Right to Inspect and Copy:** You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

Initials _____

• **Right to Amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
• **Right to an Accounting: You** generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
• **Right to a Paper Copy:** You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.
• **Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket: You** have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.
• **Right to be Notified if There is a Breach of Your Unsecured PHI:** You have a right to be notified if: 1) use or disclosure of your PHI in violation of the HIPAA Privacy Rule, b) the PHI has not been encrypted to government standards, and c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Provider's Duties:
• I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
• I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
• If I revise my policies and procedures, I will provide you with a copy of the revised policies and procedures at our next scheduled appointment.

V. Questions and Complaints
If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me so that we can discuss your concerns. If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to me at the following address:

Midtown Psychotherapy Associates
199 Armour Drive NE, Suite E
Atlanta, Ga. 30324
404-685-1600, Fax: 678-666-1149

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services, or the Georgia Board of Psychological Examiners. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy
This notice will go into effect on the date undersigned by you. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. If you are an active patient when I make a change, I will provide you with a revised notice upon your request. I will post my current privacy policy on my website.

Initials _____

I have read and reviewed this policy. I understand and agree to its contents. A copy of this document was provided to me.

_____
Client Name

_____ _____
Client Signature Date of Signature

Initials _____

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COVID-19 Informed Consent & Waiver for In-Office Services

This document contains important information about your consent to gradually resume in-office services during the COVID-19 pandemic. Please read this carefully. When you sign this document, it will constitute a contract between you and Midtown Psychotherapy Associates and affiliated clinicians, (hereinafter referred to "The Practice"). The Practice team cares about you and wants you to make an informed decision with your informed consent concerning the return to in office services. Please do not hesitate to call our office for additional information, or any concerns.

Your Responsibility and Commitment to Minimize COVID-19 Exposure

To obtain/resume in office services, you will need to sign this document and agree to take certain precautions to help keep The Practice staff, our families, and other patients safer from exposure to COVID-19, illness and possible death. By signing this document, you agree to follow all of The Practice safety policies and the health guidelines posted by The Centers for Disease Control and Prevention (CDC) to help maintain the safety of everyone who is working and those seeking services from The Practice. **Please refer to our "Policies for Resuming In-Office Services" for more details.**

If you do not adhere to The Practice "Policies for Resuming In-Office Services," we will not meet in person. You will have to call to reschedule and may be assessed a late cancelation fee. If clients generally do not comply with the policies, this will result in The Practice scheduling only telehealth appointments. **The Practice retains the right to deny appointments to anyone not complying with the guidelines** and maintains the right to return to telehealth arrangements for clients who we deem to be symptomatic, or otherwise a safety risk, in our sole discretion. The Practice may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will notify you about any necessary changes.

Maintaining Confidentiality in the Case of Infection

If you have tested positive for the coronavirus, The Practice may be required to notify local health authorities that you have been in the office. If you have tested positive and you have been in our office in the recent past, The Practice will also need to inform other clients and staff who you may have crossed paths with you so they know they have had exposure. However, please

know that if The Practice has to report this to local health authorities, The Practice 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. If The Practice informs other clients or staff that an in-office client tested positive, we will not disclose your identity or any identifying information to anyone other than your treating therapist if you have not already done so. By signing this form, you agree that The Practice may do so without an additional signed release.

Please Read Carefully

1. I understand that The Practice is **NOT** responsible for the risk associated with returning to in-office services and cannot be sued for any possible exposure to COVID-19. If I contract COVID-19 while seeking in-office services, I will not sue The Practice. As such, and in consideration of the services provided by The Practice, I individually and on behalf of my child(ren), hereby release, covenant not to sue, discharge, and hold harmless The Practice its officers, employees, agents, and representatives of and from any and all claims, including all liabilities, actions, damages, costs or expenses of any kind arising out of or relating to in office services or coronavirus exposure. I understand and agree that this release includes any claims based on the acts, omissions, or negligence of The Practice, its officers, employees, agents, and representatives, whether a coronavirus infection occurs before, during, or after participation in any in-person appointments.

2. I acknowledge and agree that if I have symptoms or have tested positive for coronavirus, I will inform The Practice, and I agree to seek treatment via telehealth and **will NOT return to in office services until a medical doctor or nurse has given me written authority to do so**. **The Practice** retains the right to cancel any appointment for any Client showing symptoms.

3. I understand and acknowledge that, by coming to the physical office, **I am responsible** for the risk of exposure to COVID-19 (or other public health risks). I understand that this risk may increase if I have a job that directly/indirectly exposes me to COVID-19 or I travel using public transportation, cab, or ridesharing services, e.g., Uber, Lyft.

4. I understand that by signing this document, I agree to follow **ALL** posted safety policies found in the **"Polices for Resuming In-Office Services"** information sheet, and I will follow guidelines posted by the CDC while seeking in-office services.

I acknowledge and agree to these terms and conditions.

_____ _____

Patient/Client Date