[Your name, address, contact information]

Date:

In accordance with local, state, and Federal guidelines during the COVID-19 public health crisis, I, **\_\_\_\_\_\_\_\_\_\_\_\_,** will resume in-person services as of **\_\_\_\_\_**. If I believe that it is not possible to keep my office virus-free, I may return to telehealth-only services for the safety of everyone.

If at any time you decide you would prefer telehealth services, I will do my best to accommodate you. By resuming in-person services, you assume sole risk of exposure to the coronavirus and any other public health risks of being in my office. I ask that you adhere to the following precautions to help keep everyone healthy:

* Wear a mask while in my waiting room or office.
* Avoid touching your face or eyes with your hands.
* Minimize your exposure to anyone who is ill between appointments.
* Keep a 6-ft distance from anyone you see in my office and waiting area.
* Plan to come to the waiting room no more than five minutes before your appointment.
* Wash your hands or use alcohol-based hand sanitizer right before entering my office.
* Do not attend your in-person appointment if you are experiencing symptoms of *any* illness.

I will continue to follow best practices to keep my office as virus-free as possible to reduce the risk of spreading the coronavirus. If anyone who has been in my office in the past two weeks tests positive for the virus, I will notify you.

Please understand that I may be required to notify local health authorities if you test positive for COVID-19. If so, I will only provide your name and address for this purpose.

If you have any questions, please let me know.

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[Patient Signature] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[LCSW Signature}\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_