Consent for Therapy for those Vaccinated against Covid-19

I, _____, consent to participate in in-person psychotherapy sessions with _____ (my therapist) at their place of business.

1. I understand the following with respect to in-person sessions during the Covid-19 pandemic:
   a. I understand that Covid-19 is extremely contagious and is spread primarily by person-to-person contact.
   b. I understand t hat my therapist has been fully vaccinated against Covid-19 and has adopted reasonable preventative measures intended to reduce the spread of Covid-19, but there is still a possibility of transmission as a result of attending in-person therapy.
   c. I understand that federal and state laws typically authorize public health departments to collect patient information to prevent or control disease and for related public health needs.
   d. I understand that my therapist may be required to report Covid-19 related patient information to public health departments, HHS, or the CDC, e.g., for contact tracing or other data collection needs. If reporting is required, only the minimum necessary information will be disclosed.
2. I agree to the following with respect to in-person sessions during the Covid-19 pandemic:
   a. I certify that I have been fully vaccinated against Covid-19.
   b. I will attach a copy of my vaccine certification to this consent form.
   c. I will comply with safety precautions to limit the spread of Covid-19, as directed by my therapist.
   d. I will notify my therapist as soon as possible before my appointment if I have symptoms of Covid-19 or anyone in my household has been diagnosed with Covid-19. If this happens, I will cancel my appointment unless my therapist directs me to come in.

I knowingly and willingly consent to have in-person sessions during the Covid-19 pandemic, and I acknowledge the health risk of Covid-19 during this pandemic. I have read the information provided above and discussed it with my therapist, and all of my questions have been answered to my satisfaction.

_____ _____
Signature of client Date

_____ _____
Signature of client Date

_____ _____
Signature of therapist Date