



COVID-19 CHECKLIST & ACKNOWLEDGMENT

Client Name _____

Date(s) of Appointment(s) _____

Date Checklist Completed _____

*Please answer the following questions. All questions must be answered prior to being seen in-office for your/your child's appointment. Please check "yes" or "no" to the following items for the **client**, as well as the **accompanying parent** (if applicable).*

1. Have you traveled out of the country in the past 14 days? If yes, please list countries below.

Client:

Parent:

YES _____ NO _____ YES _____ NO _____

If yes, list countries:

2. Have you been exposed to someone who tested positive for COVID-19 or who you believe has COVID-19 in the past 14 days?

Client:

Parent:

YES _____ NO _____ YES _____ NO _____

3. Are you currently experiencing or have you had any of these symptoms in the last 14 days: fever greater than 100; difficulty breathing; cough; flu-like symptoms; body ache; stomach ache; or other illness symptoms?

Client:

Parent:

YES _____ NO _____ YES _____ NO _____

4. Have you been exposed to someone experiencing a fever, cough, difficulty breathing, stomach aches, body aches, flu-like symptoms?

Client:

Parent:

YES _____ NO _____ YES _____ NO _____

5. Were you informed of the safety precautions taking place for your in-office appointment at the Belin-Blank Center Assessment and Counseling Clinic (BBC-ACC)?

Adult Client or Parent/Guardian:

YES _____ NO _____

6. Are you comfortable with the level of precautions being taken?

Adult Client or Parent/Guardian:

YES _____ NO _____

7. Do you acknowledge that though safety precautions are being taken, that there is still a possibility of transmission of COVID-19?

Adult Client or Parent/Guardian:

YES _____ NO _____

8. In acknowledgment of the safety precautions provided and risks involved, are you comfortable keeping your in-person appointment at the BBC-ACC?

Adult Client or Parent/Guardian:

YES _____ NO _____

9. If you responded "NO" to question 8, would you like to reschedule your appointment?

Adult Client or Parent/Guardian:

YES _____ NO _____

The Belin-Blank Center Assessment and Counseling Clinic reserves the right to reschedule any in-person appointments based on the answers provided above. In addition, if you are experiencing any of the following symptoms, please cancel or reschedule your appointment: Fever; Sore Throat; Loss of Taste or Smell; Shortness of Breath; Severe Fatigue; Flu-Like Symptoms; Cough; or, any other symptoms of COVID-19. If you are diagnosed with COVID-19 or otherwise believe you have COVID-19 within fourteen days after receiving any in-person services, immediately notify Dr. Alissa Doobay, Ph.D.

Acknowledgment and Release

If your in-person appointment is kept based on your responses above, please read and sign the following paragraphs regarding risks and liabilities.

I, _____, consent to receive (or for my child to receive) in-person psychological services during the COVID-19 Public Health Emergency. I understand that COVID-19 is highly contagious and is believed to spread by person-to-person contact, and as a result, social distancing is recommended. I understand that possible exposure to COVID-19 during _____ in-person psychological services and being in close proximity to the psychologist, staff or other clients in the waiting area may result in the following: a positive COVID-19 diagnosis, extended isolation, severe illness, hospitalization, intensive care treatment, other complications, and the risk of death. I understand that the BBC-ACC is taking reasonable precautions to limit the spread of COVID-19, yet there is still possibility of transmission.

I have made the decision to have in-person psychological services based on my own free will. I understand the risk of injury and infection, including transmission of COVID-19, and am relying on my own judgment and knowledge. My decision to obtain in-person services is not based upon duress, undue influence, false statements or other representations made by any third parties, including the BBC-ACC. This acknowledgment is not an admission of liability by the BBC-ACC. I agree to release and hold the BBC-ACC harmless from any claims or causes of action related to or arising from possible exposure or infection of COVID-19.

I have carefully read this acknowledgment and understand its contents, and I am signing it of my own free act.

Client Name: _____

Client Signature (age 12 or older): _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Psychologist Signature: _____ Date: _____