THERAKIDS PLUS, INC.

INFORMED CONSENT TO RETURN TO CLINIC BASED SERVICES

Patient:_____ Date:_____

The document below describes the guidelines, during COVID-19 pandemic, as we return to clinic based, daycare/preschool, or home-based services for Occupational, Physical, Early Intervention, and Speech Therapy services. Please read this carefully. Signature on this document reflects an official agreement between you as the parent, caregiver or patient and Therakids Plus, Inc. to return to the clinic, home, or daycare for services.

Face-to-Face Sessions

I agree to return to clinic for face to face sessions with my therapist(s). I understand that I may also be receiving a blend of telehealth and face to face sessions. I also understand that if the COVID-19 Pandemic should worsen or the health department should issue stay at home orders or close face to face opportunities, I will return to telehealth services.

At anytime, if you as the patient, caregiver, or parent decide that you would like to initiate or return to telehealth sessions, TKP, Inc. will facilitate this immediately. Telehealth can be maintained as a feasible method of treatment as long as it is clinically appropriate and able to be reimbursed by the insurance company.

Risks of Clinic Based / Home Based / Daycare/Preschool Services

I understand that by receiving in person, face to face sessions in the clinic, daycare/preschool, or home, I am assuming the risk of exposure to COVID-19 (or other public health risk). This risk may increase if you travel by public transportation. I understand there are ways that both myself and my service provider can minimize my exposure and provide a safe therapy environment.

Your Responsibility to Minimize Your Exposure

I agree to take certain precautions which will help keep safe from exposure to COVID-19. If you do not or cannot adhere to these safeguards, it may result in the initiation or return to telehealth sessions. Please initial each to demonstrate that you understand and agree to these actions:

_____I will only attend my child's appointment if all family members, including myself and my child are symptom free and have not knowingly been exposed to COVID-19.

_____I will agree to a temperature check at the clinic/daycare/preschool/home each session. If I, my child, or any family member has a temperature of 100 degrees Fahrenheit or more, or if we have other symptoms of COVID-19, I agree to cancel the appointment or proceed using telehealth.

_____I understand that there is no waiting room at TKP, Inc.; therefore I will have to wait in my car or outside in a designated waiting area, until no earlier than 5 minutes before our appointment time. I will call when I arrive and TKP, Inc. will send therapist or staff to pick up my child. When session concludes, staff will return my child to me. I understand that a ½ hour session will end 5 minutes early and an hour session will end 10 minutes early. My child's therapist(s) will arrange on a communication system with me to review progress.

_____I understand that I can attend my child's session but will have to wear a mask, including when entering the building.

_____I understand the my child and I will be required to wash our hands or use alcohol-based hand sanitizer when we enter and exit the building.

_____I understand that I will need to follow social distancing guidelines that TKP, Inc. has initiated when moving about the clinic or while in the therapy room.

_____I understand that, if appropriate, my child will be asked to wear a mask or a face shield in all areas of the office.

_____I understand that my therapist and child will try to eliminate or reduce casual physical contact (e.g. shaking hands, hugging). Appropriate physical touch during therapy session will occur.

_____I understand that if anyone in my family, including myself, has a job that exposes us to others with COVID-19 (hospital, physician, plants) I will immediately let TKP, Inc. know.

_____If I take the bus or attend large gatherings/activities that put me in close contact with others (beyond my family), I will let TKP, Inc. know.

_____If anyone in my home tests positive for COVID-19, I will immediately let TKP, Inc. know and telehealth sessions will begin for the following 14 days.

_____I acknowledge that I have received resource information about COVID-19.

**These guidelines may be subject to change based on local, state or federal orders or guidelines that are published.

TKP, Inc.'s Responsibility to Minimize Exposure

TKP, Inc. has taken steps to reduce the risk of spreading the coronavirus within the office. Please see below:

a. no waiting room – outside and car pick-up/return
b. only one patient/therapist to a room
c. patients (if appropriate) and family member are required to wear a mask, adhere to social distancing, and maintain hygiene while in clinic
d. therapists will sanitize therapy room before, during and after session
e. therapists will wear a surgical mask / cloth mask, and/or use a face shield.
f. carpets have been removed and replaced with vinyl flooring in therapy rooms. The gym has carpet but mats are used and regularly sanitized before and after use.
g. all therapists and staff have been trained on appropriate COVID-19 guidelines and precautions.
h. TKP, Inc. is transparent – If any of our staff is exposed or has the COVID-19 virus, all patients will be notified.
i. Therapists are required to cancel sessions if they are running a fever, feel ill, have been exposed to COVID-19 in any form, or have symptoms of virus.

j. therapists are required to test negative for COVID-19 prior to returning to face to face therapy sessions.

Exposure to COVID-19

With respect to contact tracing for COVID-19, If you, your child, or your family members living inside your home have tested positive for COVID-19, TKP, Inc. may be contacted by "Contact Tracers"or by local health authorities that you have been in our clinic. TKP, Inc. will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for clinic visits. By signing this form, you are agreeing that TKP, Inc. may do so without an additional signed release.

Informed Consent

This agreement supplements the informed consent for treatment that we agreed to at the start of therapy services.

Your signature below shows that you agree to these terms and conditions.

_____ _____

Patient/Caregiver Signature Date

_____ _____

Therakids Plus, Inc. Representative Date