mpa

MERIDIAN PSYCHOLOGICAL ASSOCIATES, P.C.

SUPPLEMENTAL INFORMED CONSENT FOR MENTAL HEALTH TREATMENT

I, _____, agree to hold harmless and indemnify the practitioners, associates, employees, legal representatives and management of Meridian Psychological Associates, P.C. ("MPA") against any claims and/or actions arising from and/or related to COVID-19 in exchange for any mental health or forensic psychological services (including, but not limited to: psychological assessment, psychotherapy, psychological consultation, parenting coordination, child custody evaluation, and collaborative divorce coaching). By signing this informed consent, I am choosing to receive mental health/forensic services during the COVID-19 National Emergency. I acknowledge that there may be risks associated with being in close proximity of practitioners, staff, and other patients (including severe illness and even death) and that you knowingly and voluntarily accept those risks.

Acknowledgement:

I, _____, make this decision of my own free will and using my personal judgment, fully understanding the possibility that transmission of COVID-19 is possible during treatment. My decision to enter into and execute this informed consent and waiver is not based upon duress, undue influence, coercion, false statements or other representations made by practitioners, associates, employees, legal representatives or management of MPA. I have been informed of alternative methods and manners of pursuing these services, including but not limited to postponing these services to a later date when the risks of COVID-19 contagion are better understood, managed, and mitigated, as well as using telehealth or other service modalities which do not require my in-person presence. I have been afforded an opportunity to ask any questions. Knowing the risks, I choose to have in-person treatment. Knowing the risks and recognizing that this agreement is not an admission of any liability regarding the practitioners , associates, employees, legal representatives or management of MPA against any claims or actions, I am signing this document of my own free will and signify by doing so, my understanding of its contents and my agreement to proceed with in-person services at MPA.

I also affirm that if I am experiencing any of the following symptoms that I will cancel or reschedule my appointment:

-Fever	-Sore Throat	-Loss of Taste or Smell	-Shortness of Breath
-Severe Fatigue	-Flu-Like Symptoms	-Dry Cough	

Patient's Name: _____

(Printed) * If you are the parent, list all children authorized for in-person treatment.

Patient/Parent or Guardian: _____ _____

(Signature) (Date)