Metropolitan Counseling Associates *LLC*
7201 Wisconsin Avenue, Suite 700
Bethesda, MD 20814
301.654.7770

Covid-19 Vaccination Screening Questionnaire

Have you received a Covid-19 vaccination? Yes ◯ NO ◯

How many doses have you received? Choose

Which vaccine did you receive? Pick one

Date of last dose

If YES, please provide us with your vaccination card. We will make a copy and keep it for our records.

Name

Date

Signature

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Standards for In-Person Mental Health Services at Metropolitan Counseling Associates, LLC During the Covid-19 Pandemic

1. In order to keep all clients and MCA associates safe, we require all clients to take the following safety precautions:
    a. Wait outside of the office or in the waiting room in a designated seat that allows for social distance until your appointment time.
    b. At all times, maintain at least 6 ft of distance between you and other people (including your provider) in the office.
    c. Wear a face mask while in the office.
    d. Use hand sanitizer (to be provided) upon arrival in the office and after touching your face.
    e. Refrain from eating and drinking while in the waiting room.

2. If you have any of the following symptoms, please let your provider know as soon prior to your appointment as possible to determine the safety of in-person treatment:
    a. Fever over 100 degrees (Please take your temperature before each appointment
    b. Shortness of Breath
    c. Runny Nose
    d. Sore Throat
    e. Loss of Sense of Smell

3. If you have had ANY of the following experiences in the past 2 weeks, please let your provider know and plan to have your session though telehealth:
    a. Tested positive for COVID-19
    b. Awaiting results of your own COVID-19 test
    c. Came in contact with someone in the past 14 days who has tested positive for COVID-19
    d. Regularly in close contact with others outside of your family who are NOT vaccinated
    e. In prolonged contact with others outside of your family who have NOT been vaccinated in the past 14 days

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Informed Consent for In-Person Mental Health Services During Covid-19 Pandemic

I, _____, consent to participate in in-person mental health treatment (individual, family, group, psychiatric services and/or executive functioning support) at Metropolitan Counseling Associates, LLC. at the above address.

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 that Metropolitan Counseling Associates, LLC 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 at any Associate at Metropolitan Counseling Associates, LLC may be required to report Covid-19 related patient information to public health departments, HHS, or the CDC. For example, if anyone who has been in an office at Metropolitan Counseling Associates, LLC test positive for Covid-19, disclosure may be necessary 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 will comply with safety precautions to limit the spread of Covid-19, as directed by the document entitled Standards for In-Person Mental Health Services at Metropolitan Counseling Associates, LLC During the Covid-19 Pandemic.
   b. I will notify my MCA provider(s) as soon as possible before my appointment(s) if I have symptoms of Covid-19 or have been exposed to certain risk factors listed in the Standards for In-Person Mental Health Services at Metropolitan Counseling Associates, LLC During the Covid-19 Pandemic. If this happens, I will cancel my in-person appointment.
   c. I understand that cancelled in-person appointments will automatically be replaced with a telehealth session unless otherwise determined.

I knowingly and willingly consent to have in-person sessions during the Covid-19 pandemic, and I acknowledge the health risks associated with Covid-19. I have read the information provided above as well as the attached document entitled, Standards for In-Person Mental Health Services at Metropolitan Counseling Associates During the Covid-19 Pandemic. Signing below is an indication that I agree to follow all standards listed in that document. I have discussed in-person treatment with my providers at Metropolitan Counseling Associates, LLC and all of my questions have been answered to my satisfaction.

_____

Client's Printed Name

_____ _____

Client's Signature Date

_____ _____

Parent Signature (if Client is under 18 yrs old) Date

_____ _____

Signature of MCA Provider or Staff Date