LYNDA MANDELL, M.D., PLLC

PATIENT ACKNOWLEDGMENT OF, ACCEPTANCE OF, AND INFORMED CONSENT TO POSSIBLE RISKS OF IN-PERSON TREATMENT DURING COVID-19 PUBLIC HEALTH CRISIS (Source: American Psychiatric Association)

I _____ (Patient Name) have elected to pursue in-person psychiatric treatment during the COVID-19 pandemic from Dr. Lynda Mandell (DBA Lynda Mandell MD PLLC). Dr. Mandell has been fully vaccinated and boosted against Covid-19 and she is taking the following steps to mitigate risks of COVID transmission in the in- person setting: physical distancing, availability of masks, sanitizers and on-site air purifiers.

By signing this, I attest that:

1. I am fully vaccinated against COVID-19 according to the CDC and have received one or more boosters.

2. I will only attend my in-person appointment if I am asymptomatic. If I should develop symptoms consistent with COVID-19 prior to my appointment, I will not go into the office and will make arrangements with Dr. Mandell to transfer the appointment to a virtual one, all subject to Dr. Mandell's late cancellation and no-show policy. In appropriate circumstances, in her discretion, Dr. Mandell may waive any late cancellation or no-show fees.

3. In the past 7 days, I have not had any of the following symptoms consistent with COVID-19: (i) a fever (higher than 100.4 F) or chills, (ii) cough, (iii) shortness of breath or difficulty breathing, (iv) fatigue, (v) muscle or body aches, (vi) headache, (vii) new loss of tase or smell, (viii) sore throat, (ix) congestion or runny nose, (x) nausea or vomiting, (xi) diarrhea.

4. I will immediately notify the office if I am diagnosed with Covid-19 after my in-person treatment, and arrange with Dr. Mandell for virtual treatment during any time period during which the CDC recommends that I should be in isolation or quarantine; and

5. I have not knowingly had close contact with anyone infected with COVID-19 in the past 14 days.

I acknowledge that there may still be health risks involved in visiting the office and having face-to-face contact with Dr. Lynda Mandell. I understand and voluntarily accept those risks and have elected to receive my psychiatric care in person. I hereby release and waive any right to bring suit or otherwise make any claim against Dr. Mandell or her PLLC in connection with exposure, infection and/or spread of COVID-19 related to my in-person treatment.

I further acknowledge that if there is resurgence of the virus or if other health concerns arise, including a period of isolation/quarantine for Dr. Mandell, she may choose to return my visits to a virtual format. In such event, Dr. Mandell and I will discuss the reasons for this and make arrangements for continuing care virtually. I understand that I may elect to return to telehealth visits at any time.

If I am diagnosed with COVID-19, I understand and give my consent for Dr. Mandell to comply with all required notifications to health authorities by providing the minimum necessary information for their data collection. By signing this form, I agree to this without the necessity of any additional release.

This PATIENT ACKNOWLEDGEMENT OF, ACCEPTENCE OF AND INFORMED CONSENT TO POSSIBLE RISKS OF IN-PERSON TREATMENT DURING COVID-19 PUBLIC HEALTH CRISIS supplements the general informed consent and other agreements I have with Dr. Mandell.

Agreed to this ____ day of _____ 202_

BY: _____ Patient Signature

_____ Printed Patient Name