Informed Consent

For Dr. Hogansen's Neurocognitive Evaluations During COVID-19 Pandemic

This document contains important information about our decision (yours and mine) to resume in-clinic services in light of the COVID-19 public health emergency. This consent for in-clinic services is a ***supplement*** *to the general Behavioral Health informed consent that we agreed to at the outset of our clinical work together. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.*

_____ (initials of patient/guardian) I have reviewed Dr. Hogansen's **Safety Plan** (separate document) and discussed my concerns/questions about it with Dr. Hogansen.

_____ (initials of patient/guardian) I understand that despite Dr. Hogansen's Safety Plan and The Corvallis Clinic's careful attention to safety protocols, there is still a potential **risk of exposure** that I will be exposed to coronavirus by coming to Dr. Hogansen's office at the clinic.

_____ (initials of patient/guardian) In order to proceed with Dr. Hogansen's model of testing, I agree to take certain **precautions** which will help keep everyone safer from exposure, sickness, and possible death. In addition to the procedures outlined in the Safety Plan, I specifically agree to the following:

- I will take steps in the weeks prior to my in-clinic appointment(s) to minimize my exposure to COVID-19.
- If I have a job that exposes me to other people who are infected during the evaluation process, I will immediately inform Dr. Hogansen.
- If my commute/travel or other responsibilities or activities put me in close contact with others (beyond my household) during the evaluation process, I will inform Dr. Hogansen.
- If a resident of my household tests positive for the infection during the evaluation process, I will immediately inform Dr. Hogansen so she can take appropriate precautions.
- If I/my child and/or Dr. Hogansen test positive for the coronavirus, Dr. Hogansen may be required to notify local health authorities that I have been in her office. If Dr. Hogansen is required to report this, she will only provide the minimum information necessary for data collection and will not go into any details about the reason(s) for our visits. By signing this form, I agree that Dr. Hogansen may do so without an additional signed release.

_____ (initials of patient/guardian) I understand that **standardized test administration will be modified** and this may affect results in ways that are so far unknown. These modifications have the potential to reduce confidence in the diagnostic conclusions and recommendations for treatment. There may also be a loss of data typically obtained during a face-to-face (without PPE) exam and this loss may reduce the richness of the clinical data and further limit conclusions and recommendations.

Concerns and Suggestions

If you have any questions about the Safety Plan or this Informed Consent, please call (541-754-1288). Dr. Hogansen welcomes suggestions for additional procedures that would help you and your family to feel/be safe. If your suggestion(s) will not compromise the evaluation process, they will be added to the Safety Plan and Informed Consent. You will be required to agree to and sign the revised Informed Consent.

_____

Patient Name

_____ _____

Signature of patient/guardian/parent Date