

Informed Consent, Responsibilities of Parties, and Limits of Confidentiality

- 1.** I understand the purpose and nature of the Psychology Evaluation Services, ABA Evaluation, and Behavioral Therapy Program provided by Compleat KiDZ (referred to as “CK Services” going forward), and I have been provided with an opportunity to discuss any concerns or questions I may have.
- 2.** I understand that the CK Services may be conducted in person or through confidential telehealth arrangements, as appropriate to the nature of the service provided
- 3.** I give Compleat KiDZ permission to evaluate and treat my child without my presence in the building, when the Compleat KiDZ assessment and therapy team deems it is appropriate.
- 4.** I understand that a written report may be prepared related to CK Services my child receives, which may contain information about my child, their medical history and my medical history that impacts my child’s evaluation and treatment. The report may also contain professional opinions; with which I disagree.
- 5.** I understand that these reports will be released to the third party that requested these services. I also understand that Compleat KiDZ does not have control over the entities to which the third party might release information.
- 6.** I understand that Compleat KiDZ or the individual conducting the CK Services may disclose information about my child as outlined in the Notice of Privacy Practices, including but not limited to when necessary to prevent a serious threat to my child’s health and safety or the health and safety of the public or another person; to report possible abuse or neglect of a child or vulnerable adult; when otherwise permitted or required by law.
- 7.** I understand that Compleat KiDZ has made no guarantees about my child’s progress or the outcomes my child will experience as a result of participating in ABA treatment.
- 8.** The potential risks and benefits of ABA treatment for my child have been explained to me, including but not limited to:
 - a. Potential Benefits: increasing functional communication skills, decreasing problem behaviors and general behavior management, increase in social skills/social functionality, individualized treatment, and skill acquisition.
 - b. Potential Risks: new emerging behaviors, increase in behaviors, increase in agitative behaviors during therapy, ABA therapy may not be effective in all cases, rapid progress is not guaranteed etc.
- 9.** I understand that my child is the primary beneficiary of services regardless of funding source.
- 10.** I understand that I may discontinue my child’s participation in any CK Service at any time.
- 11.** I understand and agree that neither Compleat KiDZ nor the individual conducting the CK Services are not providing any treatment to me, my child or family at the time of these services that I have not agreed to.
- 12.** I understand that the individual conducting the CK Services is not doing so in his or her capacity as my physician, that no doctor-patient relationship is created, and that doctor-patient privileges do not apply to these types of services.

Parent/Legal Guardian (Print Name)

Signature

Date

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