# Family First Center for Autism - Consent for Services

Child:

Date of Birth:

Welcome to Family First Center for Autism and Child Development! This consent form contains important information about our professional services and our business policies. This form outlines the rights and responsibilities of the clients (the child served and his/her family) and of Family First. By signing this document, you are indicating that you consent for your child to receive assessment and treatment services and that you are in agreement with our business policies.

Assessment and Treatment Services

I have been informed about the services provided by Family First. I understand that Applied Behavior Analysis (ABA) and the principles of ABA will be used in the assessment and treatment process for my child.

• I consent for my child to receive the assessment and treatment services provided by Family First. I understand that all services are directed by a Board Certified Behavior Analyst (BCBA) who is licensed in the State of Missouri. The BCBA supervises our team of behavior therapists who work 1:1 and/or in small groups with children. A licensed clinical psychologist is also on site for consultation on an as-needed basis.

### Confidentiality

• I understand that all services provided by Family First are confidential. Family First is required to obtain my informed written consent before releasing any information except where required by legislation or directed by the courts. Examples of such exceptions may include reporting suspicion of child abuse or a child in need of protection, informing someone in a position of authority if a client is in imminent danger of harming themselves or others, or providing information as directed by the courts through subpoena, search warrant, or other legal order.

### Treatment Services

• I have been informed that the assessment and treatment services are based on the principles of Applied Behavior Analysis and positive behavior modification techniques. I understand that the goal of services is to help my child function as independently as possible within the home, school, and community settings.

• I accept that my child will be rewarded (e.g., with food, praise, hugs, or preferred toys or activities) for appropriate, adaptive behaviors such as language production or social interactions.

• I understand that when my child engages in inappropriate behaviors, different interventions could be used, such as:

• Redirecting attention to the task,

• Ignoring inappropriate behaviors,

• Rewarding alternative, appropriate behaviors,

* Using physical guidance to help him/her respond to a command (e.g., helping him/her to sit on a chair).
* In the case that routinely used techniques, such as those listed above, are not effective in reducing inappropriate behaviors, the behavioral specialist will meet with the supervising Board Certified Behavior Analyst to discuss other possibilities for intervention. If any intrusive intervention is recommended and approved, I understand that I will sign a written consent form prior to any administration of these procedures.

### Assessment Procedures

• Before starting treatment services for my child, several assessment procedures will be used. These may include:

* An intake interview during which I will be asked about my child’s current and past levels of language, motor skills, play skills, self-help skills, interest in peers, and behavioral concerns,
* Standardized psychological or educational assessments to measure my child’s cognitive functioning, level of adaptive functioning in daily life, and level of receptive and expressive language,
* Behavioral and curriculum-based assessments,
* Behavioral observation of my child during free-play and during interactions with others, and
* Reports from school or past medical or psychological assessments will also be requested if appropriate.
* I understand that Family First may request a medical evaluation if a behavior appears to be caused by an underlying medical issue or to rule any underlying medical issues.
* I authorize Family First to carry out clinical and educational assessments to help direct the development of treatment services for my child. I understand that assessments may involve participation of members of my family. I understand that the results of all assessments are available to me at any time.

### Data Collection

• In order to monitor my child’s learning throughout the program, behavior specialists will complete specific data collection forms. I understand that the services provided by Family First rely heavily on the collection of data and that any data collected is confidential and will be accessible only by authorized staff of Family First.

• Assessment and treatment data may be de-identified and used for research purposes (e.g., written up for scientific journals or presented at scientific conferences). In this case, no identifying information will be shared and it will not be possible to determine if the data is that my, or any other, child. However, I have the right to state that my child’s data not be used for research purposes and there will be no negative consequences for myself or my child in his/her interactions with Family First.

**Patient Involvement in Care and Services**

* I understand that my child has the right to participate in the planning process for his/her care and may refuse services.

### Family Participation

• My participation in the treatment program is essential for my child’s learning. I will discuss with the parent trainer to identify the best way I can be involved in my child’s program, taking into account all aspects of my family. I understand that I will have to participate in the following ways:

1. Attending regularly scheduled appointments
2. Helping my child to generalize skills learned through the treatment program
3. I understand that the involvement of all family members will aid in generalization of learned skills and will increase the likelihood of positive outcomes for my child. I can discuss with the Clinical Supervisor how to best have family members involved.
4. I understand that if I have questions or concerns regarding my child’s ability to generalize skills, I may ask my child’s therapist to provide me with additional training.
5. I understand that Family First will provide additional information, guidance, and educational materials to help me best support my child’s growth and development. Topics covered will include behavior health information and care options.
6. I understand that parent training will also include learning about service planning, transition planning and discharge planning. My BCBA will utilize my input to help make appropriate decisions.
7. I understand that the BCBA in charge of my case would be happy to help with finding additional support and community resources for my family. Our BCBA will also be available to collaborate with my child’s educational team as well as additional health care professionals. If Family First is unable to meet the needs of my child, they will assist me in making a referral to a more appropriate agency.

### Food Reinforcers

• I understand that, when appropriate, food may be used a reinforcer. I will keep Family First updated on any allergies my child may have. I will also refrain from allowing my child access to certain foods that are being used specifically for treatment purposes. This will increase the likelihood that they will serve as powerful reinforcers.

### Benefits and Risks

• I understand that the possible benefits of our participation in this program are as follows:

• My child’s mental age, social, and adaptive functioning may improve,

• I may become a more effective teacher for my child than I am now,

• Because I do not need to be present during all therapy hours, I may have more time to attend to my own or family needs,

• Information collected on my child may lead to the improvement of services for other children with autism or related disorders.

• I understand that although the treatment provided is intended to be beneficial and has helped children like mine in the past, participation may involve some of the following risks or discomforts for my child:

* It is possible that the program may not help my child to improve his/her abilities,
* My child may present some behavior problems during or after therapy hours,
* My child may experience some distress (e.g., crying) when the behavior specialists are teaching new skills such as sitting on the chair or sitting in front of a new therapist,
* I understand that I have a choice to comply or not comply with recommended treatments. If I have any questions or concerns regarding treatment recommendations it is my responsibility to discuss them with my BCBA. Failure to follow through with recommendations will decrease the generalization of skills and may jeopardize the success of treatment.

### Videotaping

• I understand that my child and/or my family will be videotaped during therapy sessions. During the therapy, they will be used for many purposes, including:

• To help with training of behavior specialists for both my child and other children

• To help with redesigning my child’s treatment program

• For teaching purposes for my child (e.g., video modeling)

• I understand that any videotapes will be used ONLY for treatment or training purposes. For any other purposes, the Board Certified Behavior Analyst will ask me directly if I will allow the use of my child’s tape within specific conditions and my written consent will be required. I understand I have the right to view, at any time, any video tapes of my child. If saved, all video tapes will become a part of my child’s treatment file and will be stored for the time period required by law, however, I understand that I can request they be erased at any time.

### Agreement for Programming

• I understand that I will need to agree to the treatment curriculum and all programs that are developed for my child. Each treatment program will be explained to me and I will need to sign it prior to implementation. I understand that I can discuss any disagreements with the Board Certified Behavior Analyst and that no programs will be implemented without my support.

Business Policies

• I understand that Family First provides a range of assessment and treatment services. I understand that following initial evaluation, Family First will work with me to develop a comprehensive curriculum and program plan.

• I understand that I do not have to continue working with Family First, even if the assessment process has already begun. I can discontinue my child’s involvement with Family First at any time.

• I agree that if Family First does not think it is the appropriate program to best serve my child’s needs, they will attempt to help me identify more appropriate services and will make my child’s assessment information available upon my request.

### Session Times

• I agree to work with Family First to determine the appropriate number of hours for my child’s treatment. I understand that the higher the intensity of services, the greater the likelihood of positive outcomes. I also understand that regularly scheduled sessions are important for consistency and that there is a greater the likelihood of positive outcomes when sessions are scheduled regularly.

• I understand that if I need to cancel a session, I will do my best to contact Family First at least 24 hours in advance. Family First will also attempt to contact me within 24 hours if a session needs to be cancelled.

### Payment

• I understand that the hourly rate for services provided by Family First is $50 and that this may be broken down for periods of less than one hour. I understand that I will be required to provide payment on set payment due dates (to be determined at the time that weekly hours are scheduled), unless otherwise agreed to in writing or unless my insurance requires another arrangement.

• I understand that Family First will assist me in receiving any insurance benefits to which I am entitled, however, I acknowledge that ultimately I will be responsible for the payment of fees to Family First, not the insurance company. I understand it is my responsibility to read my insurance coverage booklet and to contact my plan administrator should I have any questions. If it is necessary to clear confusion, Family First will be available to contact the insurance company on my behalf.

• I understand that if my account has not been paid for more than 90 days and arrangements for payment have not been made, Family First has the option of using legal means to secure the payment, including the hiring of a collection agency or going through small claims court.

• I am aware that Family First may be required to provide information on my child’s services to my insurance company and that the information required may include personal information. I understand that Family First will make every effort to release only the minimum information about my child that is necessary for the purpose requested. I understand that once this information is provided to the insurance company, Family First will have no control over it or how it is used. I understand that, upon request, Family First will provide me with a copy of the information provided to the insurance company.

• By signing this consent form, I agree that Family First can provide any requested information about my child and his/her assessment and treatment services to my insurance company.

• I agree to work with Family First to review my insurance coverage and their treatment recommendations to determine goals for treatment with the intention of maximizing services with the resources available.

### Contacting Family First

• I understand that staff of Family First may not always be readily available by phone or email, however, I acknowledge that attempts will be made to respond to any messages will be returned within one business day.

• I understand that if I am not able to wait for the staff of Family First to respond to my message, I should contact my family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. I agree to call 911 in the event of any life threatening emergencies.

• I understand that emails are not a confidential way to contact Family First and that personal information contained in emails may be accessible to third parties.

* I understand that if I have concerns or complaints about services or treatment, I should contact the Clinical Director, Dr. Farrell Weiers at (816)984-8280. Dr. Weiers will provide verbal information regarding the method used to resolve the complaint upon request.

### Professional Records

• I understand that the laws require that my child’s Protected Health Information be kept in his/her clinical record. The clinical record contains information about the assessments, the curriculum, individual programs, and any treatment records obtained from other providers.

• I understand that I have access to my child’s clinical record at any time. I acknowledge that Family First recommends that the file be initially reviewed in the presence of the Clinical Supervisor, as some of the technical information may difficult to interpret for an untrained reader.

• I understand that HIPPA provides me with rights to have my child’s file amended, to restrict specific information available to others, to request an accounting of most disclosures of PHI that have not been authorized, to determine the locations to which PHI has been sent, to have any complaints about Family First recorded in the files, and to have a paper copy of this consent, the HIPPA notice form, and Family First privacy policies and procedures. I also understand that I can discuss any of these issues with staff from Family First and I have the right to have all of my questions answered.

### Minors and Parents/Guardians

• I understand that if a client is under the age of 18, parents/guardians have the right to access youth files.

• I understand that Family First recommends that both parents/guardians provide consent for assessment and treatment and that in some cases consent from both will be required.

### Confidentiality

• As discussed above, I understand that my child’s information will be confidential and will not be shared with others unless required by law.

• I understand that should I wish my child’s information to be shared with other practitioners or educators, I will need to complete a Request/Authorization to Release Confidential Records and Information stating exactly what information is to be shared.

• I understand that Family First may be required to share some information about my child with others for professional reasons, such as billing, scheduling, or answering service. I understand that all of these individuals will be held to the same confidentiality expectations as Family First.

MY SIGNATURE BELOW INDICATES THAT I HAVE READ THIS CONSENT FORM AND AGREE TO ITS TERMS. MY SIGNATURE ALSO INDICATES THAT I HAVE RECEIVED A COPY OF THE HIPPA NOTICE OF PRIVACY PRACTICES. ALL OF THIS INFORMATION HAS BEEN EXPLAINED TO ME, I HAVE BEEN GIVEN AN OPPORTUNITY TO ASK QUESTIONS, AND I HAVE HAD ALL OF MY QUESTIONS ANSWERED.

Parent/Guardian Printed Name Date

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Parent/Guardian Signature Date

Child/Minor Date