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Guardian Consent Form & Program Policies

Rev. March 2019

*This document must be completed by all guardians for home programs by the 1st visit or the clinician **cannot continue with services** (due to the inherit risks & safety issues we need to be aware of for to effectively treat your learner) cannot come out for a 2nd visit.*

Learner Name: **Last:** **First:** **MI:**

Other Names Used: **Date of Birth:**

Address:

Home Phone: ( ) **Cell Phone: ( )**

Guardian's Name: _____ Email Address REQUIRED:_____

Number of Homes Services will take place: ____ Emergency Contact Phone: _____

Please circle yes or no

Does your learner suffer from any conditions requiring medical treatment, previous medical problems, or any changes to his/her medical condition? **Yes** **No**
Write Details here:

Does your learner suffer from any allergies, including food allergies? **Yes** **No**
List Allergies and if prescribed Epipen:

Does your learner have any special dietary requirements? **Yes** **No**
Write Details here:

Does your learner have any medical conditions that could place him/her at risk should a protective hold or physical prompting be necessary to ensure his/her safety? **Yes** **No**
Write Details here:

In the event that your son/daughter exhibits behaviors that endanger his/her safety or the safety of others, it may be necessary to implement a protective hold to ensure safety. Although unlikely, physical prompting or protective holds could result in redness to the skin, minor bruising or swelling, or other accidental injuries if the student resists the procedures. Do you consent to the use of a protective hold and physical prompting procedures? You may withdraw your consent at any time in writing. ***"NO" RESPONSES MAY PREVENT OUR AGENCY FROM PROVIDING ANY SERVICES OR MAY LIMIT THE TYPE OF SERVICES PROVIDED.*** Do you consent to the use of these procedures to ensure his/her safety? **Yes** **No**
If "No" is circled, please contact Executive Vice President, Matt Linder, by email to explain the rationale for this at matt@brettdassociates.com Services will not start until this is resolved.

Does your son/daughter take any medication and are there any side effects that should be monitored closely? *(Note: we do not administer medication & our staff must be informed of any medication time that could occur during an outing in the community)*
Write Details here: **Yes** **No**

I hereby give my consent for my son/daughter to be involved with Brett DiNovi & Associates (BDA) in-home or school consultation programs. I acknowledge this is a voluntary program and that I have the option to terminate services as I so desire. I understand that there may be occasions when consultants may need to transport my son/daughter for activities related to program goals. I thereby authorize Brett DiNovi & Associates consultants to transport my learner.
Yes **No**

I hereby give my consent for a functional behavior assessment(s) and implementation of positive behavior intervention plans as needed at the discretion of BDA clinical staff.
Yes **No**

Guardian Initials Here _____

For all Cases:

I give consent to medical treatment should an injury occur.	**Yes**	**No**
I give consent for our clinicians to video tape, photograph, & use a HIPAA compliant remote video consultation platform my son/daughter to be used for: behavioral data analysis & staff training which **is required**.	**Yes**	**No**
I consent to the use of pictures posted on a closed private Facebook group that other parents and BDA staff may see.	**Yes**	**No**
I consent to the public use of pictures and videos in environments and media such as, but not limited to the BDA office, the BDA website, and BDA YouTube® channel.	**Yes**	**No**
I hereby authorize BDA access & to share the protected health information (child study team records & any medical or psychological reports from all sources, etc.) with other interdisciplinary providers in my son/daughter's health record from today's date until one year of service from today (or upon termination of BDA services).	**Yes**	**No**
I understand giving gifts to any clinicians within my home may result in their loss of certification and ability to provide for their families and my own.	**I will not give gifts to BDA employees**	
I consent to be contacted by way of text about changes in schedule, upcoming events, and other information pertinent to service provision.	**Yes**	**No**
I understand that several months may go by before the program is staffed to your satisfaction. If this condition is not agreed to, we cannot begin services.	**Agree**	**Delay Start**
A BDA representative will reach out regularly to ensure you are pleased with our services. We are not soliciting anything but feedback. We understand your time is valuable and thank you for it.		
Are there Animals in the Home (Allergy Purposes)?	**Yes**	**No**
• If so, Please list types (cat, dog, etc.) _____		

For Insurance Cases Only:

I understand that any out of pocket maximum &/or deductible must be paid to BDA prior to or at the time of service until this amount is met, or I can produce an explanation of benefits from my insurance company demonstrating this has already been met. I understand that BDA requires a 24-hour notice of a cancellation or my insurance will still be billed for the session and a make-up session may be scheduled at the discretion of the staff member that was scheduled. I acknowledge that if there are any changes with my insurance plan I am obligated to inform Linda Mitchell at Brett DiNovi & Associates at linda@brettdassociates.com of the change immediately and I am responsible for any charges associated with the change in insurance. I agree to the cancelation policy and also to notify Linda immediately in the event that I change my insurance company coverage. I acknowledge that, should my health insurance deny coverage for this ABA service, I am responsible for payment for services rendered.

I understand that if I must cancel appointments, BDA is not required to make up those hours missed, although; all attempts will be made to reschedule the appointments. I also understand that BDA may exercise the right to discontinue services and transition them to another provider should conditions in the home, such as implementation of the program with poor procedural integrity, place the learner at risk.

I agree to hold Brett DiNovi & Associates LLC, its officers, directors, subcontractors, employees, representatives and agents harmless and indemnify BDA and those trained in these techniques from any and all lawsuits, damages, injuries and claims that may arise or relate to any training or services offered to your son, daughter, or caretakers. **I agree to be present (for home programs)** for training while BDA staff work with my son/daughter unless written permission is given for other arrangements.

_____ _____
Printed Name of Guardian Date

_____ _____
Signature of Guardian Consent Date

Please fax or scan & email completed form to
Melissa Woshnak at mwoshnak@brettdassociates.com or fax 480-393-4069