Dear prospective client,

Greetings! Thank you for your interest in psychological assessment and/or therapy services at Progressive ABA Therapy Group, LLC. We are excited to start the evaluation process with you and/or your child. We hope the process helps you learn more about your child and helps them meet their fullest potential.

Here, you will find several important forms and documentation that must be completed prior to starting the assessment process. Please complete the forms in their entirety. A checklist is provided below to ensure all documentation is complete. We also ask that you provide our team with pertinent medical and educational records such as copies of other diagnostic evaluations, Individualized Education Plans (IEP's), and educational evaluations (ETR) so we have a complete background on your child. We look forward to working with you and your child. Thank you for selecting us to be a part of this process!

Sincerely,

PSYD, BCBA-D, LP

Dr. Kristopher Brown, PsyD, LP, BCBA-D, COBA
Licensed Psychologist (Ohio)
Board Certified Behavior Analyst-Doctoral
Certified Ohio Behavior Analyst

Traducción disponible bajo petición
可应要求提供翻译
Traduction disponible sur demande
الترجمة متاحة عند الطلب
Услуги перевода доступны по запросу

5500 Market Street Suite 119
Youngstown, OH 44512
Phone: 330-518-2109; Fax: 330-532-0042
therapy@proaba.org

Introduction

Dear client,

Thank you for choosing Progressive ABA Therapy Group for a psychological evaluation. It means a lot to me and our company that you have trusted us for this important step in your child's treatment. This introduction is to tell you a little bit about me and my background. Of course, if you have any additional questions, please feel free to reach out to me at kjbrown@proaba.org.

Sincerely,

PSYD, BCBA-D, LP

Dr. Kris Brown, PsyD, LP, BCBA-D, COBA

BACKGROUND AND EXPERIENCE:

Originally, I wanted to go to school to be a teacher. After I took my first psychology class, I was very interested and changed majors. While I was an undergraduate, I was a student worker at The Rich Center for Autism at Youngstown State University. This is where I developed my interest in working with individuals with developmental delays like autism, ADHD, intellectual delays, and behavior disorders.

After I got my bachelor's in psychology, I obtained my Master of Science in Applied Behavior Analysis (ABA) from Youngstown State University. While in my master's program, I completed 1,000 hours of supervised training at The Rich Center and Summit Academy Schools. After passing a national certification exam, I became a Board Certified Behavior Analyst (BCBA) in 2014. I worked as a supervisor in clinics, schools, and community settings providing treatment to children and young adults. I am also certified to practice ABA in Ohio as a Certified Ohio Behavior Analyst (COBA).

In 2016, I decided to go back to school to become a clinical psychologist. I completed my Doctor of Psychology (Psy.D) in Clinical Psychology from California Southern University in 2020. After I graduated, I completed a 3,600 hour postdoctoral internship in clinical psychology at Hope and Healing Counseling Center in Hubbard, Ohio. While in my post-doc, I also completed additional training and published articles on ABA and became certified as a Board Certified Behavior Analyst-Doctoral (BCBA-D). I completed my post-doc in clinical psychology in 2023 and became a licensed psychologist in Ohio later that year.

PRACTICE STRUCTURE AND CLARIFICATION OF ROLES:

I co-own Progressive ABA Therapy Group and occasionally provide ABA services as a BCBA to clients there. When I obtained my psychologist's license, I decided to offer psychological services in addition to the ABA services we offer at Progressive ABA Therapy Group. Our goal in doing so is to provide more comprehensive care to clients. However, clients who receive ABA with Progressive ABA Therapy Group ***do not*** have to contract with me for psychological assessment/evaluation services. Likewise, clients who request psychological assessment services ***are not*** required to engage in ABA therapy with Progressive ABA Therapy Group. I also pledge not to give special preference to clients who indicate they might be interested in therapy with Progressive ABA Therapy Group or let the fact that Progressive ABA Therapy Group provides services influence the diagnosis or services I provide to you and/or your family.

Item 1: Informed Consent for Psychological Testing and Psychotherapy

Welcome to Progressive ABA Therapy Group and the psychological practice of Dr. Kris Brown. I look forward to working with you and your child to identify their strengths, areas of difficulty, and your concerns/goals as a parent. When assessments are complete, my goal is to make recommendations that are aimed at helping your child and family to function better. This document contains important information about psychological assessments, the privacy of your information, my fees, supervisees working under my direction, and mandated reporting so you can have enough information to consent to working with me. When you sign this document, it will represent an agreement between us.

WHAT IS PSYCHOLOGICAL TESTING?

Psychological evaluation is a process that includes a combination of clinical interview, completion of written questionnaires, and the use of a variety of standardized measures in two or more one-on-one appointments with your child or adolescent. Depending upon the individual concerns and questions to be answered by the evaluation, testing may include (but are not limited to):

- Assessment of intellectual development (i.e., IQ testing)
- Developmental testing
- Neurodevelopmental disorder symptoms evaluation (i.e., autism, ADHD)
- Language and vocabulary skills (i.e., social language, expressive/receptive vocabulary)
- Adaptive skills (i.e., socialization, activities of daily living, functional communication)
- Academic skills and learning problems
- Attention and executive functioning skills
- Behavioral and emotional functioning (i.e., anxiety, aggression, conduct problems)
- Memory skills (i.e., working memory, auditory working memory)

I use tests and assessment measures that are accepted within the profession of psychology and appropriate for the reason for evaluation.

WHAT IS THE PROCESS OF EVALUATION?

The first appointment is an initial evaluation, which typically includes a discussion with you and/or your child about the current concerns and difficulties. This also gives me an opportunity to observe the child interact with you and me, as well as their play skills. Subsequent appointments are when testing occurs. Our last appointment will be a feedback regarding the results of the evaluation. During the feedback, I review scores, provide a diagnostic formulation, and make recommendations (psychological prescription) for treatment.

At this first meeting, you may be asked to provide additional records, such as report cards and prior testing reports and, for your written authorization to provide permission to communicate with other professionals involved in your child's care. I also make use of secure online assessment portals to get more information from you. For instance, I might send a symptoms checklist to you via email to get more information about your or your child's symptoms.

USE OF THE EVALUATION REPORT:

After the written report has been prepared and shared, the usual next step is to share the report with other involved professionals, including but not limited to the school team, the pediatrician, and other medical professionals. On many occasions, parents set up a meeting at the school to go over the recommendations and determine if additional supports can be put in place. I can only send the report with written authorization from you to do so.

Many parents request evaluations to help their child in school or to get an IEP. Please be aware that it is not in my control whether a school will agree to assess your child for an IEP. My recommendations will be practical, driven by the test data, and relevant to the needs of your child in the context of the evaluation results. If school is reported to be an issue, I will discuss so in the recommendations.

STATEMENT ON DIAGNOSIS:
Payment for services and consent to services are for *the psychologist's time and expertise when applying a diagnosis.* This **is not the same** as *consenting for a specific diagnosis.* This means that the psychologist will apply the most appropriate diagnosis based on test scores, observations, and clinical judgement. Dr. Brown utilized the current diagnostic criteria in *The Diagnostic and Statistical Manual for Mental Disorders 5th Edition Text Revision* (DSM-5-TR) when making a diagnosis. The psychologist is not under any obligation to provide a specific diagnosis. The psychologist reserves the right to apply a diagnosis you might not agree with (but will explain their reasoning and provide a written report). You cannot "unconsent" to a rendered diagnosis or request that the psychologist delete, strike out, alter, or remove diagnoses for convenience, funding needs, based on what your impressions are, what online screener instruments indicate, information from the internet, information from pop culture, etc. However, Dr. Brown looks forward to and always includes information from clients, their views, and background when formulating a diagnosis. If additional information is provided that is factual and relevant, diagnoses can be modified or changed based on new information. You are allowed and encouraged to seek a second opinion about a diagnosis when you have questions about the diagnosis rendered and/or disagree with it.

WHAT IS THE PROCESS FOR PSYCHOTHERAPY?
Psychotherapy (sometimes called talk therapy) refers to a variety of treatments that aim to help a person identify and change troubling emotions, thoughts, and behaviors. Most psychotherapy takes place when a licensed mental health professional and a patient meet one-on-one or with other patients in a group setting (NIH, n.d.). During psychotherapy, we might discuss your symptoms, identify methods to reduce them or discuss barriers to doing so. We might identify triggers for emotions (past or present), challenge ways of thinking, or directly practice skills that I think might help reduce mental health symptoms you have. The specific interventions we use will depend on our initial discussion in treatment.

CONTACTING ME:
The best way to reach me is through email (kjbrown@proaba.org) or via phone/ voice mail at 330-991-9117. Please be aware that I do not answer calls when I am in appointments, but I check voice mail often. I will make every effort to return your call within 24 – 48 hours, except for weekends and holidays, but I cannot guarantee that this is always possible. If you are not able to reach me and feel that your child is having an acute mental health emergency and you cannot wait for a return call, please contact your child's medical provider or go to the nearest emergency room.

SPECIAL CIRCUMSTANCES:
I provide consultation, psychological evaluation, and psychotherapy services to assist with problem resolution, to provide diagnostic determinations for psychological conditions, and recommend treatment. I do not complete specialized evaluations to be used in legal proceedings, such as for forensic issues or court proceedings for custody determination. I do not complete workers' compensation evaluations. I cannot and do not prescribe psychotropic medication. If you anticipate, or I determine, that these are needed, I will refer you to professionals who have this area of specialization in their practice.

OUT OF STATE CLIENTS:
Dr. Brown is licensed in Ohio. However, his office is close to the border of Pennsylvania and Ohio. Dr. Brown can only practice in the state of Ohio. He cannot complete telehealth visits while you are in Pennsylvania because this is practicing out of the state of Ohio. Dr. Brown is not licensed in any other state and cannot guarantee his evaluation or assessment will meet the criteria for services in other states.

COURT/LEGAL FEES:
As mentioned, I do not conduct evaluations for the purposes of court orders, legal proceedings, custody proceedings, or other forensic areas. Although very unlikely, it is important that I share the following information in advance: If I am required by subpoena or court order to testify in any matter related to the psychological evaluation services, you will be expected to pay for all the professional time used, including preparation and transportation costs, even if I am called to testify by another party. If I am subpoenaed by another party in litigation with you, and you do not wish the subpoena answered, it is your responsibility to contract with your lawyer to quash the subpoena or to sign a waiver of confidentiality.

Because of the substantial difficulty of managing such legal involvement while maintaining scheduled appointments in my practice at the same time, the fees are $ 350 per hour for preparation, records review, and attendance at any legal proceeding. This is in addition to costs for mileage, lodging, food, travel, and other costs incurred from responsibilities related to involvement in a legal case.

RECORDS:
I will maintain a record of your services in accordance with confidentiality rules and regulations. I will keep your record for a duration consistent with state and federal laws. In Ohio, records for adults are kept for 7 years past the last date of service. For minors, records are kept for 7 years after the relationship ends **or** 2 years past the age of majority (18), whichever is longer. I will store records in a locked area that is not publicly accessible to others. If you request a copy of your records, I will not send session notes that I take as part of my case formulation. I may charge a fee to make a paper copy of the records if it is over **20 pages.**

Agreement and Consent
For Item 1: Psychological Testing and Psychotherapy

_______ (initial) I have read the accompanying informed consent policy before signing.

Your signature below indicates that you have read the information in this agreement and agree to abide by its terms during our professional relationship. By your signature below, you indicate that:

- You have been informed of and understand the type of services to be provided. You consent to the procedures specified in this consent agreement. You can withdraw your consent at any time by letting me know in person, by phone, or by email.
- You have been informed of the limits of confidentiality and my duty to report certain incidents.
- You understand and agree to the insurance, payment, collection, and cancellation policies.
- You accept full responsibility for all fees incurred in completing the psychological evaluation as spelled out in the agreement.
- You understand that, if you are provided with a digital copy of the report, you are not permitted to make any changes to the report. Doing so is considered fraud, and I will report this to the appropriate agencies.

____ _________________
Signature of Patient (or Parent/Guardian) Date

____ _________________
Printed Name of Patient (or Parent/Guardian) Date

____ _________________
Signature of Patient (or Parent/Guardian 2) Date

____ _________________
Printed Name of Patient (or Parent/Guardian 2) Date

____ _________________
Signature of Minor Patient over 14 (if applicable) Date
☐ minor patient over 14 is unable to sign due to developmental condition.

____ _________________
Witness Date

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therapy@proaba.org
Version 2.4 October 2024

Item 2: Informed Consent for Psychological Work Supervisee

This form outlines important information about the use of psychological assistants under Dr. Kris Brown's supervision who will provide psychological assessment services. These individuals are not licensed psychologists. They perform these tasks under the direction of Dr. Kristopher Brown, PsyD, BCBA-D, COBA, LP. Dr. Brown provides oversight, training, and supervision to the psychological assistants. The benefit of using assistants is that more services of a competent nature can be made available to clients than if Dr. Brown were practicing on his own. This means you may receive your report and recommendations more quickly when a psychological assistant provides some of the psychological work required during an evaluation. You do not have to consent to the use of a psychological assistant to complete your or your child's assessment, **however,** this can result in your report process taking longer than expected.

All psychology assistants must follow the same ethical guidelines as Dr. Brown. If you have a concern regarding the performance of an assistant or your evaluation process, please feel free to contact Dr. Brown with the contact information provided above.

☐ I consent for psychological assistants to provide psychological assessment procedures as a part of my or my child's psychological evaluation. I understand these individuals are not licensed psychologists, but instead work under Dr. Brown. I understand how to contact Dr. Brown and understand that Dr. Brown is responsible for the assessment work, diagnosis, and recommendations arising from work done under his supervision.

☐ I do not consent for psychological assistants to provide psychological assessment procedures as a part of my or my child's psychological evaluation.

Item 2: Informed Consent for Psychological Work Supervisee

____	__________________________
Client/Parent Signature Printed Name: ______________________________ Parent to minor child: __________________________	Date
____	__________________________
Dr. Kris Brown, PsyD, BCBA-D, LP Licensed Psychologist-Ohio (P.08535)	Date
____	__________________________
Supervisee Signature (If applicable) Printed Name: Tim DeAngelis, Aide to Psychologist Supervisee to Dr. Kris Brown, PsyD, BCBA-D, LP (P.08535) Licensed Psychologist-Ohio (P.08535)	Date

Item 3: Confidentiality Statement

All interactions that take place at Progressive ABA Therapy Group during therapy are considered confidential information. This includes requests by telephone, all interactions with technicians, interactions with supervisors, any scheduling or appointment notes, all session content records, and any progress notes completed that describe the content of treatment sessions.

Any information collected during therapy is confidential and is to be treated in the same manner as communications between a lawyer and their client. Progressive ABA Therapy Group cannot even verify that you are a client to a 3rd party without a release of information. You may choose to give us permission in writing to release any or specific information about you to any person or agency that you designate.

Limits to Confidentiality

There are limits to confidentiality. They include:

- A court order from a judge. This would require a clinician at Progressive ABA Therapy Group to provide information about the order.
- If Progressive ABA Therapy Group learns about or has evidence to believe that there is physical, mental, sexual abuse, and/or neglect of any minor under 18 years of age, we must report this information to county child protection services.
- If Progressive ABA Therapy Group learns about or has evidence to believe that there is physical, mental, sexual abuse, and/or neglect of any person with a developmental disability up to 21 years of age, we must report this information to county child protection services.
- If Progressive ABA Therapy Group learns about or has evidence that an elderly person is being abused, neglected, or exploited, we must file a report with the appropriate state agency that handles elder abuse.
- If Progressive ABA Therapy Group learns of or believes that a client poses an imminent risk of serious harm to another person and we believe the individual can do so, we are obligated to take protective measures. This could include reporting the threat, facilitating hospitalization, or creating a treatment plan to reduce the risk.
- If there is evidence that a client is an imminent risk of danger to themselves and/or is likely to commit suicide, Progressive ABA Therapy Group is obligated to take protective measures such as contacting family members or others who can help provide protection, coordinating mental health treatment, or contacting authorities who can care for the client.
- **For minors:** If you tell someone you work with at Progressive ABA Therapy Group that you want to hurt yourself or hurt someone else, and we think that you really mean it and plan on doing it, we must tell your parents and possibly the police.

There may be times when staff at Progressive ABA Therapy Group consult with each other or seek input from outside sources about cases. In these cases, **no personally identifiable information will be used to discuss this case**. The persons with whom I discuss cases are legally bound to keep information confidential.

Other Specifications Regarding Confidentiality in Psychological Evaluations

The following are confidentiality limits regarding psychological assessments. Some may be the same as those outlined above. Please read these to ensure you understand all limits to confidentiality. In general, the privacy of communication between a patient and a psychologist is protected by law, and I can only release information to others with your written permission. There are a few exceptions you should be informed:

- In proceedings involving custody or those in which your child's emotional condition is an issue, a judge may determine that my testimony will be ordered. If you choose to include your child's mental or emotional status as part of a court proceeding, doing so waives your privilege of confidentiality.
- If a patient or patient's parent or guardian files a complaint or lawsuit against me, I may disclose relevant information regarding that patient to defend myself.
- If I have reason to believe that a child under 18 **or** an individual with a developmental delay up to the age of 21 has been or is being subjected to abuse or neglect, the law requires that I file a report with the appropriate government agency.
- I suspect or have reason to believe **an adult over 60 who is vulnerable because of aging** is the victim of abuse, neglect, or exploitation, the law requires I file a report with the appropriate agencies.
- If a client or knowledgeable person communicates to me that a client indicates the intention to inflict imminent physical injury or death upon a specified victim, and I believe the client has the intent and means to do this, I am required to take protective action to eliminate the possibility that the patient will carry out the threat. This could include suggesting hospitalization for the client, taking any action I have available to me to involuntarily hospitalize the client, formulating a treatment plan to reduce the risk and getting a second opinion, notifying the police/authorities in the area where the intended victim resides, and notifying the family of the intended victim.
- If you submit your bill to your insurance company for reimbursement, they require that I provide a clinical diagnosis and may also request clinical information. If your company requires forms to be completed to request authorization for psychological testing, these forms may include clinical information and diagnoses that are faxed to the company for review or discussed in a telephone call with a reviewer employed by the company.
- If you are divorced, **both parents have equal ability to obtain information from mental health records** and **both parents must give permission for the provision of psychological services unless I am provided a valid court order that states otherwise**. If a situation like one of those described above occurs, I will make every effort to fully discuss it with you before taking any action. Otherwise, I will not tell anyone anything about you or your child's evaluation or even that you are a patient, without your knowledge and written consent.

Signature and Agreement for
Item 3: Confidentiality Policy Acknowledgement

_______ (initial) I have read the accompanying informed consent policy before signing. I understand the limits of confidentiality described above. I have had the opportunity to ask questions about the policy.

___________________________________ ___________________________________
Parent Date Witness Date

____
Client (if over 14) Date

☐ Check is client is over 14 but, the opinion of a professional, cannot clearly assent due to a developmental disability, language delay, and/or possible intellectual impairment that impairs their ability to have these rights explained to them

Item 4: Fees and Payment Policy for Psychological Evaluations

A complete psychological evaluation involves the initial appointment, scoring and interpretation of any questionnaire measures sent via a secure electronic assessment portal, followed by face-to-face testing measures with the examiner, usually over two to three appointments and taking seven to eight hours total. **After this,** scoring the tests, interpretation of the results, and the preparation of a written evaluation report. The process of scoring, directing tests, interpreting scores, and report writing can take as many hours as administering the tests themselves. **The diagnostic report and recommendations are provided at the end of this process. I will not provide diagnostic impressions or recommendations without sufficient professional information to do so.**

Fees for psychotherapy services are billed for service rendered and occur per date of service. I will recommend a service intensity (weekly, bi-weekly) depending on your presenting condition and my professional opinion. My fees for psychological services are as follows:

Psychotherapy	
Initial Psychiatric Diagnostic Evaluation	$200.00 for evaluation
Individual Counseling/Psychotherapy	$200.00 for 60 minutes $150.00 for 45 minutes $100.00 for 30 minutes
Group Counseling/Psychotherapy	$200.00 for 60 minutes $150.00 for 45 minutes $100.00 for 30 minutes
Interactive Complexity	$50.00 (per session)
Psychological Testing and Evaluation Services	
Licensed Psychologist-Testing and Evaluation Services	$200.00 per hour
Registered Psychology Assistant- Testing and Evaluation Services	$200.00 per hour

INSURANCE INFORMATION:

Currently, I am in network with many insurance panels. Before service is started, we will **attempt** to call the insurance company with the information your provided to verify benefits. However, it is strongly suggested you also call and inquire about the coverage for psychological assessment services.

If you do not have insurance or I am not in-network with your insurance, you are responsible for payment of all charges, submission of bills to your insurance company, obtaining information about your coverage and making certain that we are both aware of any authorization requirements for psychological testing. If you have insurance, you are responsible for all co-insurance payments or other fees prior to any deductible is met. I will provide you with detailed receipts, including all the necessary information, should you choose to submit to your insurance company for reimbursement. Many insurance plans cover psychological services, and many require the member to make a telephone call before an initial appointment. If you are interested in submitting for reimbursement, I recommend that you contact your insurance company to request information about out-of-network benefits for psychological consultation and testing prior to the first appointment. If you call your insurance company, let them know that you are calling for "preauthorization for psychological testing services" They may ask you for CPT Codes. These are listed below:

Service	Code
Initial Psychiatric Diagnostic Evaluation	90791
Individual Counseling/Psychotherapy	90837 for 60 minutes 90834 for 45 minutes 90832 for 30 minutes
Group Counseling/Psychotherapy	90849
Interactive Complexity	90785
Licensed Psychologist-Testing and Evaluation Services	96130, 96131 96132, 96133 96136, 96137
Registered Psychology Assistant- Testing and Evaluation Services	96138, 96139

I suggest that you obtain any special forms and a fax number for the paperwork that they tell you is required. If your insurance company authorizes the testing, they will use the date they receive the forms for the start date of the authorization. I am not in control of how quickly they will process this request or whether they will authorize testing at all. I will fill out forms if you provide them for me and will give you a copy of the forms that I submit so that you can follow up with them directly. **Any co-payments or deductibles are due at the time of service. If you have medical insurance that I am contracted with, I cannot see you as a self-pay client.**

PAYMENT POLICY:
I accept cash, check, or credit/debit payments for services. I am open to making payment arrangements with families in case one is needed. **I will not waive the co-pay or deductible specified in any insurance plan.** If a bill for service is issued, it is required to be paid by the due date on the invoice. If I do not receive payment for services rendered by the due date and/or no payment arrangement is made by the due date you explicitly agree that I can:

1. Stop the assessment at its current stage. I will render whatever diagnosis or impressions I can make based on the available information up to that point in the evaluation.
2. Contract with and utilize a collection agency of my choice to obtain payment for services delivered. If this occurs, I will release information to this company that allows them to do their job, but not information regarding your psychological condition, diagnosis, or functioning.

Fees for psychotherapy services are billed for service rendered and occur per date of service. I will recommend a service intensity (weekly, bi-weekly) depending on your presenting condition and my professional opinion. My fees for psychological services are listed later in this packet.

I suggest that you obtain any special forms and a fax number for the paperwork that they tell you is required. If your insurance company authorizes the testing, they will use the date they receive the forms for the start date of the authorization. I am not in control of how quickly they will process this request or whether they will authorize testing at all. I will fill out forms if you provide them for me and will give you a copy of the forms that I submit so that you can follow up with them directly. **Any co-payments or deductibles are due at the time of service.**

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PAYMENT POLICY:
I accept cash, check, or credit/debit payments for services. I am open to making payment arrangements with families in case one is needed. **I will not waive the co-pay or deductible specified in any insurance plan.** If a bill for service is issued, it is required to be paid by the due date on the invoice. If I do not receive payment for services rendered by the due date and/or no payment arrangement is made by the due date you explicitly agree that I can:

1. Stop the assessment at its current stage. I will render whatever diagnosis or impressions I can make based on the available information up to that point in the evaluation.
2. Contract with and utilize a collection agency of my choice to obtain payment for services delivered. If this occurs, I will release information to this company that allows them to do their job, but not information regarding your psychological condition, diagnosis, or functioning.

ATTENDANCE AND CANCELLATION POLICY (Updated 5/15/2024)
If you must cancel an appointment, please give a minimum of 12 hours advance notice. If this minimum is not provided, you will be charged a cancellation fee of $ 100 for the initial appointment or family feedback meeting and a $200 fee for the cancellation of a testing appointment. Excessive cancellations, even when attempting to reschedule, can result in referral to another provider who might better meet you and your family's needs.

No-Call No Show to Appointments: There are many children and young adults who are on a wait list for evaluation services. When clients no call no show to appointments, significant time that could be used for another client is lost. No call no shows also extend the duration of evaluations for clients. Therefore, if you no call no show to 2 appointments, the evaluation process will end where it is currently at. Dr. Brown may render a diagnostic impression based on what information is available. If not enough information is available, he can document this in writing and provide referrals as needed.

Timeliness of Evaluations: Dr. Brown wants to get all evaluations done in a reasonable amount of time. After the initial appointment, he usually sends out an assessment via email to be completed. Once complete, he will schedule a 2nd appointment. If you do not complete the evaluation, cannot be reached to schedule by phone or email, and/or do not contact Dr. Brown regarding the evaluation within 2 weeks, you run the risk of being placed on waiting list and having the evaluation discontinued. Dr. Brown and his aide(s) will attempt to track the progress of the assessment, however **it is also part of the client's responsibility to reach out if there is a problem completing the assessment and/or scheduling problems.**

If you are the parent of a young child/toddler, the issue of timeliness becomes more important. If (for example) Dr. Brown completes the intake evaluation on 3/1/2024 and the assessment sent via email is not completed until 4/1/2024, a month of time has passed. During this month, your child could have learned new skills that might not have been captured during the initial evaluation appointment on 3/1/2024.

<u>Consent and Agreement</u>
<u>Item 4: Fees and Payment Policy for Psychological Evaluations</u>

_______ (initial) I have read the *Fees and Payment Policy for Psychological Evaluations* before signing below.
_______ (initial) I have read the *Attendance and Cancellation Policy.*

Client's Name ____ DOB ________________________
Parent's/Guardian's Name ___________________________________

Please read and initial each item below, then sign at the bottom.

<u>Check one of the following:</u>
_______ I or my child's medical insurance is covered by Ohio Medicaid (i.e., CareSource, United Healthcare Community, Molina Healthcare, Buckeye, Humana Healthy Horizons, Anthem Medicaid, AmeriHealth Caritas Ohio)
_______ I or my child's medical insurance is covered by private medical insurance through an employer or other entity.

_______ I request payment of authorized insurance benefits or subsidies made, on my behalf, payable to Progressive ABA Therapy Group, LLC for any services provided to me or my child. I authorize any holder to release to my insurance company medical information about my child needed to determine benefits or the benefits payable for related services, regulatory compliance, state audit or quality assurance purposes.
_______ I understand that Progressive ABA Therapy Group, LLC will submit my insurance claims and that I will be responsible for any deductible, co-payments, co-insurance or client fees at the time services are rendered. I understand that I will receive a monthly statement if my account has a balance due. I understand that Progressive ABA Therapy Group, LLC cannot accept responsibility for collection of my insurance claim or for negotiating a settlement on a disputed claim and that I am responsible for payment of my account. I understand that Progressive ABA Therapy Group may use means such as collection agencies and litigation if I fail to pay my bill for charges that were delivered.

_______ Based on the submitted insurance information and other available funding, the estimated cost for ABA services to your family is: ___________. Progressive ABA Therapy Group can provide you an itemized estimate based on your information by request. We also provide payment plan options on an as needed basis.
***Note:* If you or your child are covered by Ohio Medicaid, this amount is customarily $0.00. However, if you have primary insurance, let us know because the claim may need to be submitted to the private insurance first before being sent to Ohio Medicaid.**

___________________________ Parent/Client Signature ___________________________ Date

___________________________ Witness Signature ___________________________ Date

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Version 2.4 October 2024

Item 5: Notice about Concerns (No Signature Needed)

At Progressive ABA Therapy Group, we take your concerns seriously. We have an open-door policy. If you have concerns or would like to make a complaint related to your child's treatment, or treatment team, please notify the Ethics Officer at Progressive ABA Therapy Group (Dr. Kristopher Brown, PsyD, BCBA-D) at your earliest convenience. Progressive ABA Therapy Group provides the contact information below when treatment begins for *transparency* on our part.

Reporting to the State Board of Psychology of Ohio

The State Board of Psychology in Ohio also certifies behavior analysts for practice in Ohio with the certified Ohio behavior analyst (COBA) credential and licensed psychologists. The state has separate ethics guidelines and practice requirements for practicing ABA in Ohio other than the BACB. These rules of professional conduct can be found here: https://codes.ohio.gov/ohio-administrative-code/rule-4783-7-01

The board also has rules of professional conduct for psychologists. Those can be found here:

https://codes.ohio.gov/ohio-administrative-code/rule-4732-17-01

If you are concerned with the practice of a COBA or psychologist, the State Board of Psychology in Ohio can be reached at the following link:

https://psychology.ohio.gov/Enforcement

Mailing Contact:
Vern Riffe Center for Government and the Arts
77 S. High Street, Suite 1830,
Columbus, OH 43215-6108
(614) 466-8808

Reporting to Autism Commission on Quality

Progressive ABA Therapy Group is accredited by the Autism Commission on Quality (ACQ) through the Council of Autism Service Providers (CASP). ACQ accredits organizations that provide applied behavior analysis (ABA) services to consumers. The review our policies, how we provide services, and other important ways Progressive ABA Therapy Group operates to ensure we are providing high-quality services. The ACQ accreditation standards are available here:

https://autismcommission.org/standards/

If you are concerned with any practices of Progressive ABA Therapy Group and our adherence to accreditation standards, a disciplinary concern can be reported here:

https://autismcommission.org/report-an-alleged-violation/

Item 6: Authorization of Release of Information

Client Name: ____ Date of Birth: ______________________
Parent Name: _______________________________________ Client Phone: ______________________
Client Address: ____
Dates of Records Requested: __________________________ Purpose: Psychological Evaluation

Requesting Agency: Progressive ABA Therapy Group
5500 Market Street Suite 119
Boardman OH 44512

Attention: Dr Kristopher Brown, PsyD, LP
Phone: 330-991-9117 Fax: 330-532-0042
Email: kjbrown@proaba.org

I ____ (parent/legal guardian), authorize Progressive ABA Therapy Group, LLC to **release and exchange** protected health information as listed below with the following providers in either written or verbal communication for the purposes of treatment development and coordination of care.

Provider	Organization	Address and Phone	Purpose	Information Shared
Pediatrician Primary Care Physician	________________ ________________ ________________ ________________	________________ ________________ ________________ ________________	___ Collaborate Care ___ Obtain Information for Assessment ___ Complete psych evaluation ___ Other: ____________	___ Entire record ___ Treatment plan ___ Behavior plans ___ Assessments
Home School District	________________ ________________ ________________ ________________	________________ ________________ ________________ ________________	___ Collaborate Care ___ Obtain Information for Assessment ___ Complete psych evaluation ___ Other: ____________	___ Entire record ___ Treatment plan ___ Behavior plans ___ Assessments
Behavioral/ Mental Health Treatment	________________ ________________ ________________ ________________	________________ ________________ ________________ ________________	___ Collaborate Care ___ Obtain Information for Assessment ___ Complete psych evaluation ___ Other: ____________	___ Entire record ___ Treatment plan ___ Behavior plans ___ Assessments
Speech (SLP) Occupational Therapist (OT) Physical Therapist (PT)	________________ ________________ ________________ ________________	________________ ________________ ________________ ________________	___ Collaborate Care ___ Obtain Information for Assessment ___ Complete psych evaluation ___ Other: ____________	___ Entire record ___ Treatment plan ___ Behavior plans ___ Assessments
Early Intervention Help Me Grow	________________ ________________ ________________ ________________	________________ ________________ ________________ ________________	___ Collaborate Care ___ Obtain Information for Assessment ___ Complete psych evaluation ___ Other: ____________	___ Entire record ___ Treatment plan ___ Behavior plans ___ Assessments
Other Service Provider	________________ ________________ ________________ ________________	________________ ________________ ________________ ________________	___ Collaborate Care ___ Obtain Information for Assessment ___ Complete psych evaluation ___ Other: ____________	___ Entire record ___ Treatment plan ___ Behavior plans ___ Assessments

This consent will automatically expire one (1) year after the date of my signature as it appears below. I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

______________________________ ____________________ ______________________________
Parent/Legal Guardian Signature Date Relationship to Client

______________________________ ____________________
Witness Signature Date

Item 7: Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.

- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting our director and privacy officer, Dr. Kris Brown, at 330-991-9117
- You can file a complaint with the U.S. Department of Health and Human Services Office for by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- **If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures
How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you
We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services
We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease and helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Use of pre-existing data for research

- We can use or share pre-existing information for health research if the information is not identifiable to you or your child.
- For example, we might compile data on test scores within an age group to see if they are helpful for identifying a condition. This information might be presented/published/used without you or your child's name, address, or other identifying information attached. For example, the report might say *"Client A was 18 months old and score 100 on the Test of Infant Development".*
- If pre-existing data was used for such research, an ethics review board or institutional review board would have to approve for the use of this pre-existing data for the proposed research.
- Dr. Brown does not complete assessments for the purpose of completing research or alter assessments based on a research agenda in any way.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

These policies are in effect as of October 3rd, 2024.

Acknowledgement and Consent

I have read the "Notice of Privacy Practices" above and understand how my information will be used. This includes how information can be used for insurance reimbursement, to comply with the law, for research purposes, reporting abuse, and other situations. I have had a chance to ask Dr. Brown questions regarding this policy. If I have any questions after signing, I can call Dr. Brown at 330-991-9117.

______________________________ ____________________

Client/Parent to Client Date

______________________________ ____________________

Witness Da

Client Intake Questionnaire	
Note: Many of these questions are phrased as if they apply to children. If the service recipient is an adult and/or adult with a guardian. Please provide pertinent information as it applies. For example, if the question asks, "Is your child on medication?" please indicate the medication YOU or the adult is taking.	
Client Name: ___ Address: ___ City: ___ State: ___	Date of Birth: ___ Family Language: ___ Zip: ___

Parent/Legal Guardian Information

Marital status of parents: ☐ Married ☐ Separated ☐ Divorced ☐ Single

Was child adopted? ☐ Yes ☐ No

Is the client an adult who has a legal guardian? ___ Yes ___ No (if yes, please provide copy of court order)

Mother's Name: ___

Address ☐ Same as clients

If different from client's ___

City: ___ State: ___ Zip:___

Email: ___ Phone: ___

Mother's Employer: ___

Custody Status for Mother (circle): Sole custody Joint custody No legal rights

Father's Name: ___

Address ☐ Same as clients

If different from client's: ___

City: ___ State:___ Zip:___

Email: ___ Phone:___

Fathers Employer: ___

Custody Status for Father (circle): Sole custody Joint custody No legal rights

Legal Guardian Name:___

Address ☐ Same as clients

If different from client's:___

City:___ State:___ Zip:___

Guardian's Employer: ___

Email:___ Phone:___

Siblings or Other Household Members

Name: ___ Age: ___ Relationship: ___	Name: ___ Age: ___ Relationship: ___
Name: ___ Age: ___ Relationship: ___	Name: ___ Age: ___ Relationship: ___

Billing Information

--IF YOU PROVIDED A COPY OF YOUR INSURANCE CARD SKIP THIS SECTION—

Primary Insurance:

Policy Holder Name: ___________________________ Insurance Carrier: ______________________________
Insurance Policy No.: ___________________________ Insurance Group No.: ___________________________
Policy Holder Date of Birth: _____________________ Policy Holder Social Security: _____-_____-______
Employer: _____________________________________
Employer Address: ____
City: _____ State: _____ Zip: _____ Employer Phone: _______________________________

Secondary Insurance:

Policy Holder Name: ___________________________ Insurance Carrier: ______________________________
Insurance Policy No.: ___________________________ Insurance Group No.: ___________________________
Policy Holder Date of Birth: _____________________ Policy Holder Social Security: _____-_____-______
Employer: _____________________________________
Employer Address: ____
City: _____ State: _____ Zip: _____ Employer Phone: _______________________________

Medical Information

Who is your child's pediatrician/doctor?: ____
What office/clinic is the pediatrician at?: ____
City: _________________________ State: __________ Zip:________________ Phone #:______________________

Medical Diagnosis (i.e., asthma, diabetes, low weight, etc.): ____
Diagnosed by? ________________________________ Child's Age when Diagnosed: _________________________

Does your child/adolescent have any vision problems? ☐ Yes ☐ No
If yes, please explain below and if there are any treatments currently being used for correction.
Treatment: ____

Does your child/adolescent have any hearing problems? ☐ Yes ☐ No
If yes, please explain below and if there are any treatments currently being used for correction.
Treatment: ____
Is your child on medication? No/Yes (If yes, please list below)

Medication	Dosage	Purpose	Notes

Progressive ABA THERAPY GROUP

Birth and Developmental History	
Length of pregnancy ___________________	Delivery method: ________________________
Were there complications during pregnancy? If so, list:	
Birth Weight: __________________________	Birth Length: ____________________________
Were there complications for mother and/or infant after delivery? If so, list:	
Was child in the NICU? _________________	If yes, how long: _________________________
Was child jaundiced? ___________________	
How was child fed initially? ☐ breastmilk ☐ formula ☐ breastmilk and formula ☐ special feeding circumstances: ____	

Developmental Milestones ***Provide your best 3 month range estimate (i.e., started walking between 9-12 months)***		
My child rolled over at:	*☐ Not yet met*	Between _____and_____ months
My child crawled at:	*☐ Not yet met*	Between _____and_____ months
My child walked at:	*☐ Not yet met*	Between _____and_____ months
My child babbled at:	*☐ Not yet met*	Between _____and_____ months
My child started saying words at:	*☐ Not yet met*	Between _____and_____ months
My child used phrases at:	*☐ Not yet met*	Between _____and_____ months
My child was toilet trained at:	*☐ Not yet met*	Between _____and_____ months
Notes on milestones:		

Social/Emotional Behavioral Information

What does your child like to do at home for fun? What do they play with?

____

____

____

Does your child regularly play with things that are not toys (sticks, lights, fans, strings,)?

____

____

____

What is your child's diet like? Do they like different/new foods?

____

____

Progressive ABA THERAPY GROUP

Does your child regularly play with things that are not supposed to be toys (sticks, lights, fans, strings)?

How does your child act when they are happy? Do they laugh or smile? Jump? Make a special noise?

How would your child respond if another child comes up and tries to play with them?

Does your child ever approach children to try and get them to play?

How would your child respond if a stranger in the community smiled at them and waved to them?

Does your child enjoy activities like spinning in circles, looking at toys closely or from different angles, watching lights go/off, or repeating words from favorite movies or songs?

How does your child communicate without words? Do they point to things they want? Do they nod their head for yes and no? Do they wave hi or goodbye? Can they beckon for you or give a thumbs up?

Are there any activities that your child really likes to do or really dislikes because of how the behavior feels to them? Examples include not liking hair being touched, problems with certain clothing, really liking water, being startled by certain sounds or unexpected sounds, smelling things, or putting toys in their mouth?

How does your child act when they get hurt?

Item 8: Telehealth Notice and Agreement

At the conclusion of the psychological evaluation, Dr Brown may give you the choice to meet via secure video communication to discuss the results. This discussion is not part of an ongoing therapeutic relationship and does not indicate that Dr Brown is available for ongoing visits related to your child's evaluation (unless otherwise specified).

Per the Ohio Board of Psychology, you are being provided the following notice regarding the use of telehealth.

License holders practicing telepsychology shall:
(a) Conduct a risk-benefit analysis and document findings specific to:
(i) Whether the client's presenting problems and apparent condition are consistent with the use of telepsychology to the client's benefit; and
(ii) Whether the client has sufficient knowledge and skills in the use of the technology involved in rendering the service or can use a personal aid or assistive device to benefit from the service.
(b) Not provide telepsychology services to any person or persons when the outcome of the analysis required in paragraphs (H)(6)(a)(i) and (H)(6)(a)(ii) of this rule is inconsistent with the delivery of telepsychology services, whether related to clinical or technological issues.

- ***If you have a laptop or internet-connected cellular device, you can be provided a secure link to a HIPAA-compliant and encrypted video feed. Per Dr. Brown's analysis, feedback for a psychological evaluation is appropriate for telehealth services.***

Upon initial and subsequent contacts with the client, make reasonable efforts to verify the identity of the client;
(d) Obtain alternative means of contacting the client;
Provide to the client alternative means of contacting the licensee;
(f) Establish a written agreement relative to the client's access to face-to-face emergency services in the client's geographical area, in instances such as, but not necessarily limited to, the client experiencing a suicidal or homicidal crisis;
In an emergency, please call 911. Dr. Brown's use of telehealth is for communicating test results and not management of ongoing mental/behavioral health issues.
(g) Licensees, whenever feasible, use secure communications with clients, such as encrypted text messages via email or secure websites and obtain and document consent for the use of non-secure communications.
We use such communication that is HIPAA compliant
(h) Prior to providing telepsychology services, obtain the written informed consent of the client, in language that is likely to be understood and consistent with accepted professional and legal requirements, relative to:
(i) The limitations and innovative nature of using distance technology in the provision of psychological or school psychological services.
Limitations include not being face to face and the risk of disconnection. Since this meeting is not going ongoing therapy, there is no continued risk related to treatment.
(ii) Potential risks to confidentiality of information due to the use of distance technology;
Dr. Brown uses encrypted video that is HIPAA compliant. Dr. Brown can control risks to individuals overhearing his conversation in his office. You should ensure you are in a private place when taking a electronic video call.
(iii) Potential risks of sudden and unpredictable disruption of telepsychology services and how an alternative means of re-establishing electronic or other connection will be used under such circumstances;

Dr Brown will contact you by telephone if there are technological problems that interfere with telehealth feedback for a psychological evaluation.

(iv) When and how the licensee will respond to routine electronic messages;
If you send an email to Dr Brown after the report process is complete, he may answer if the question it brief. If it is a question that would require re-evaluation you and your child will be scheduled at the earliest available time (like any other client) to meet and re-initiate the diagnostic process.
(v) Under what circumstances the licensee and service recipient will use alternative means of communications under emergency circumstances;
Since the treatment relationship ends with the final report review, there will be no ongoing messages.
(vi) Who else may have access to communications between the client and the licensee;
There is no permanent product from the video. There are no saved recordings of the meeting or transcripts.
(vii) Specific methods for ensuring that a client's electronic communications are directed only to the licensee or supervisee;
The meeting links are unique and HIPAA compliant video programs are used.
(viii) How the licensee stores electronic communications exchanged with the client;
Any emails are stored on a HIPAA compliant server used by Progressive ABA Therapy Group. None else has access to Dr Brown's email (kjbrown@proaba.org).
(7) Ensure that confidential communications stored electronically cannot be recovered and/or accessed by unauthorized persons when the licensee disposes of electronic equipment and data;
Emails are kept and deleted in accordance with HIPAA regulations. Progressive ABA Therapy Group utilizes EnGuard HIPAA compliant emails and cloud storage.
(8) If in the context of a face-to-face professional relationship the following are exempt from this rule:
(a) Electronic communication used specific to appointment scheduling, billing, and/or the establishment of benefits and eligibility for services; and,
(b) Telephone or other electronic communications made for the purpose of ensuring client welfare in accord with reasonable professional judgment.

Consent and Agreement

Given the above information, you consent to telehealth visit(s) to review assessment results and reports for you and/or your child. This is not a consent for ongoing counseling or psychotherapy for you, your child, or family. It is only for the assessment process you are currently engaged in with Dr Brown. To help identify you, the email you provided will be used to send a link to.

Signature: ______________________________
Date: __________

Witness: ______________________________
Date: __________