BLUEPRINT BEHAVIORAL CONNECTIONS

Client Informed Consent & Acknowledgement of ABA Program Policies and Procedures
This is to acknowledge that I have been provided with and understand the following information.
1. The general nature and purpose for in-home autism therapy services and the roles of the team members involved.

2. Client responsibilities relating to treatment.
3. Alternatives to treatment modes.
4. Consequences of not receiving proposed treatment.
5. Clinic hours.
6. Treatment costs.
7. How to access emergency services.
8. Client rights and grievance procedure.
9. Criteria for discharge from treatment.
10. Minimal of (2) hours advance notice for cancellation of an appointment. 11. My rights to request consultation with consulting BCBA.
12. Confidentiality of client information.

I consent to the treatment plan as described by my Treatment Therapist until such time as I terminate treatment with Phoenix Behavioral Health Services, LLC. I understand that I may withdraw informed consent for treatment at any time by submitting such a request in writing to my Treatment Therapist.

HIPAA NOTICE OF PRIVACY PRACTICES:

I acknowledge receipt of the HIPAA Notice of Privacy Practices for Phoenix Behavioral Health Services, LLC. Questions or Concerns about privacy rights, Phoenix Behavioral Health Service's privacy-related policies or the information contained in this notice, contact Chief Privacy Officer of Blueprint Behavioral Connections at Blueprintbehavioralconnections@gmail.com

I have declined a paper copy of HIPAA Practices _____
I have received a paper copy of HIPAA Practices _____

CONSENT TO CONTACT:
I give my express permission to Blueprint Behavioral Connections and its Affiliates or contractors to contact me for any purpose at the current or any future numbers that are provided for landline telephone, cellular telephone or any wireless device including the use of automated dialing equipment, prerecorded voice or text messages.
I have agreed to be contacted by employees of Blueprint Behavioral Connections.

Client Name (printed)_____

Parent/Guardian Signature_____ Date_____ Clients may request a copy of this consent form if they wish to have one for their records.