Consent for Services

Please read and complete the following form to provide consent for therapy services, including telehealth, at Thrive Therapeutic Services.

Consent for Services Form, Including Telehealth

Client Information

- **Full Name:** _____
- **Date of Birth:** _____
- **Address:** _____
- **Phone Number:** _____
- **Email Address:** _____

Parent/Guardian Information (if applicable)

- **Parent/Guardian's Full Name:** _____
- **Relationship to Client:** _____
- **Phone Number:** _____
- **Email Address:** _____

Consent for Therapy Services, including Telehealth

I, the undersigned, hereby consent to the provision of Applied Behavior Analysis (ABA) therapy services, including telehealth services, for the above-named client at Thrive Therapeutic Services. I understand and agree to the following:

1. **Nature of ABA Therapy:** I understand that ABA therapy is a scientifically based approach to understanding and improving behavior. The therapy may involve structured activities, behavior assessments, and interventions aimed at improving social, communication, and life skills. Telehealth services may involve remote sessions using secure video conferencing platforms.
2. **Individualized Treatment Plan:** I acknowledge that the therapy plan will be tailored to the client's unique needs and goals, whether delivered in person, at a personal

residence, school, or through telehealth. Regular assessments will be conducted, and adjustments to the treatment plan may be made as needed.

3. **Parent/Guardian Involvement:** If applicable, I understand the importance of parent/guardian involvement in the therapy process, whether in person or during telehealth sessions. Regular communication with parents/guardians is essential for the success of the therapy.
4. **Telehealth Sessions:** I understand that telehealth sessions may involve the use of video conferencing technology. I acknowledge the potential benefits of telehealth services, including increased accessibility and reduced travel time. I also understand that there are potential risks, including technical issues, and I agree to address any concerns promptly.
5. **Confidentiality:** I understand that the information shared during therapy sessions, including telehealth sessions, is confidential. Thrive Therapeutic Services will not disclose information to third parties without proper authorization, except as required by law. Measures will be taken to ensure the security and privacy of telehealth sessions.
6. **Record Keeping:** I acknowledge that Thrive Therapeutic Services will maintain records related to the client's therapy, including telehealth sessions, and I have the right to request access to these records.
7. **Cancellation Policy:** I understand the cancellation policy of Thrive Therapeutic Services and agree to provide advance notice of any cancellations or changes to scheduled appointments, including telehealth sessions.
8. **Financial Responsibility:** I acknowledge that I am financially responsible for all services rendered, whether in person or through telehealth, and agree to pay any applicable fees, co-pays, or deductibles associated with the therapy services.
9. **Emergency Medical Treatment:** In the event of a medical emergency, I authorize Thrive Therapeutic Services to seek emergency medical treatment on behalf of the client.

Authorization

I, the undersigned, consent to the terms outlined above and authorize Thrive Therapeutic Services to provide therapy services, including telehealth services, to the client named above.

Client's Signature (or Parent/Guardian if applicable): _____

Date: _____

Thrive Therapeutic Services Representative: _____

Date: _____