**Consent for Applied Behavior Analysis Services**

This document describes the nature of the agreement for professional services, the agreed upon limits of those services, and rights and protections afforded under the Behavior Analyst Certification Board’s (BACB) guidelines for responsible conduct of Behavior Analysts.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ agree to have my child/dependent, \_\_\_\_\_\_\_\_\_\_\_\_\_ participate in applied behavior analysis (also known as ABA) assessment and/or treatment services provided by Weathers Developmental & Behavioral Therapy, PLLC (also known as Weathers Therapy, or WBD therapy) I understand that the specific activities, goals, and desired outcomes of these ABA services will be fully discussed with me and that I will have the opportunity to ask for clarification prior to signing this document.

I understand that I have the right to ask questions throughout the course of service delivery to ensure my full participation in services. If these services have been arranged or will be paid for by a third party (e.g., school, insurance plan, state agency), I am aware that the third party has the following rights: determination of services, implementation of services, access to documentation of sessions for billing purposes, access to assessment results and written reports.

I understand that my child/dependent is the primary client of the behavior analyst and that services will be designed primarily for the client’s benefit. Any other individuals or agencies (e.g., family, school professionals) who may be affected by that may be affected by the ABA services are considered secondary clients.

If the ABA services focus on increasing the client’s skills, I understand that the first session will be conducting an assessment and evaluating the client’s current skill level. The next few sessions will allow the BCBA and/or RBT to determine which instructional strategies and interventions will most likely be effective. The time allocated to the assessment will result in improved interventions as well as building a rapport with the client. The assessments will allow BCBA to design an intervention that is fit for the client’s needs and improve ongoing problem behavior. I understand that the beginning services will include functional assessment and/or functional analysis activities (e.g., interviews, checklists, direct observations) that are designed to provide information critical to the development of effective treatment procedures. I may be asked to assist in gathering some of this information by recording problem behavior as it occurs or in other ways. This process may take 1-3 weeks prior to implementing intervention, but will increase the likelihood of effective intervention.

The subsequent services will be focused on development of and implementation of instructional procedures and/or a behavior intervention plan. Prior to implementation, I will receive a printed copy of the results of any assessment and of any proposed instructional procedures or behavior intervention plans for my approval. The contents of those documents will be explained to me fully and any questions I have will be answered to my satisfaction. Subsequent implementation will involve training in the basics of ABA that are important for the intervention, details about the specific components of the ABA intervention, and direct practice in the components for the family, educators, and/or other service providers. Full participation (including but not limited to: attendance and participation in client sessions, parent training sessions, parent and team meetings, review of data, and data collection) in these implementation and training activities is critical for a successful outcome. . If there is evidence of repeated lack of involvement, Weathers Developmental & Behavioral Therapy, PLLC, reserves the right to revisit and reconsider the appropriateness of services. Ongoing collection of data will allow evaluation of the effectiveness of the intervention and will assist in developing any revisions that need to be made to ensure a good outcome. When services are no longer necessary or appropriate due to age, skill level, or other reason, we will discuss the discontinuation of services, as we will have achieved our therapeutic objectives. In addition, at regular progress reviews we may also discuss whether continuation of services would be beneficial, and any barriers to continuation. As a parent or caregiver, I have the right to request to speak to the Board Certified Behavior Analyst (BCBA) to discuss and review data being collected.

Behavior analysts are ethically obligated to provide treatments that have been scientifically supported as most effective for the client. I am aware that other interventions that I am pursuing may affect my child’s response to ABA treatment. Thus, it is important to make the behavior analyst aware of those interventions and to partner with the behavior analyst to evaluate any associated therapeutic or detrimental effects of those interventions. BCBA’s can discuss with professionals upon my consent.

I understand that the procedures and outcomes of all assessment and treatment services are strictly confidential and will be released only to agencies or individuals specifically designated by me in writing. In addition, the fact that my child/dependent receives any services is protected and private information. I am aware that Weathers Developmental & Behavioral Therapy, PLLC may release information without my prior consent if so ordered by a court of law. I am also aware that providers are legally required to report suspected occurrences of child abuse or neglect or if I or my child present clear and present danger to ourselves or to others.

I understand that the provider agency employs individuals at Weathers Developmental & Behavioral Therapy, PLLC that are supervised by a Board Certified Behavior Analyst (BCBA). I understand that the client’s assessment and treatment services may be observed by supervisors or other employees as part of ongoing training and quality assurance activities. I am aware that a record of the treatment will be maintained and this record is available to me in written form upon request.

I reserve the right to withdraw at any time from these services and I understand that such a withdrawal will not affect the client’s right to services. In the event of withdrawal, I may request a list of other credentialed providers in the region. In addition, I reserve the right to refuse, at any time, the treatment that is being offered.

I am aware that the relationship between the provider and the client is a professional one that precludes ongoing social relationships, giving of gifts, or participation in personal events such as parties, graduations, etc.

In addition, I understand that I (or a designated caregiver with written consent) must be present for all sessions conducted in the home or community setting. I understand that I am responsible for adhering to the payment arrangements, attendance, and cancellation policy set forth in a separate document.

I may request a copy of my assigned BCBA’s current professional credentials upon request. In addition, any concerns that I have about the performance of my assigned BCBA or the assigned RBTs/BT, I can notify Weathers Developmental & Behavioral Therapy, PLLC. If concerns are unable to be resolved, parent can report to:

Behavior Analyst Certification Board, Inc.

Disciplinary Matters  
8501 Shaffer Parkway  
Littleton, CO 80127

These polices have been fully explained to me, and I fully and freely give my consent and permission for my dependent

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian (legally authorized representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian (legally authorized representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Kasi Weathers, M.S., BCBA Date

Owner/BCBA

Weathers Developmental & Behavioral Therapy

BCBA Certificate # 1-19-35099

**First of all, thank you so much for selecting Weathers Developmental and Behavioral Therapy! We are grateful and appreciative that you have selected us to provide the necessary therapy to improve your child’s developmental skills. Therapy will be provided in-home, in community, or at school!**

**We know you have many options and we appreciate you entrusting us with your child!**

**In order to help with the intake process we will need a few documentations:**

**ABA intake/Application**

**Copies of most recent Psychological Evaluations**

**Copies of Autism diagnosis**

**Copy of most recent Speech, OT, and PT evaluations**

**Copy of most recent medical evaluations or Well-Child Visit report**

**Copy of insurance card (front & back)**

**Consent for Applied Behavior Analysis**

**Copy of most recent IEP**

**Thank you again for your interest in our services. Please do not hesitate to contact with any questions or concerns. We will help you!**

**Thank you again!**

Kasi Weathers, MS, BCBA

**Kasi Weathers  
501-259-3720**[**Kasiweathersbcba@gmail.com**](mailto:Kasiweathersbcba@gmail.com)

**ABA Intake Form**

|  |  |
| --- | --- |
| **Client’s information** | |
| **Last name:** | **Today’s date:** |
| **First name:** | **Age:** |
| **Middle Name:** | **Birthday:** |
|  | **SSN:** |
| **Phone number:** |  |
| **Address:** | |
| **Primary Diagnosis (and date):** | |
| **Secondary Diagnosis (and date):** | |

**Medical Information**

|  |  |  |
| --- | --- | --- |
| **Is your child allergic to anything?** | | |
| **Is your child on medication?** | | |
| **Name of Medication** | **Frequency** | **Dosage** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Physician Information**

|  |  |
| --- | --- |
| **Name & Phone # of Client’s Primary Care Provider:** | |
| **Name & Phone # of Client’s autism diagnosing physician (and level):** | |
| **List other physicians involved in your child’s care :** | |
| **Name:** | **Specialty:** |
| **Name:** | **Specialty:** |
| **Name:** | **Specialty:** |
| **Name:** | **Specialty** |

**Insurance**

|  |  |
| --- | --- |
| **Medical Insurance Provider:** | |
| **Policy #:** | **Group #** |
| **Plan name:** |  |

**Mother or Legal Guardian Information**

|  |  |
| --- | --- |
| **Full name:** | |
| **Relationship to child** | |
| **Address (if different)** | |
| **Phone Number:** | **Email:** |
| **Occupation** | **Employer:** |
| **Best way and time to contact?** | |

**Father of Legal Guardian Information**

|  |  |
| --- | --- |
| **Full name:** | |
| **Relationship to child** | |
| **Address (if different)** | |
| **Phone Number:** | **Email:** |
| **Occupation** | **Employer:** |
| **Best way & time to contact** | |

**Siblings:**

|  |
| --- |
| **Name and Age:** |
| **Name and Age:** |
| **Name and Age:** |
| **Name and Age:** |
| **Name and Age:** |

**School or Daycare information**

|  |  |
| --- | --- |
| **Name of school or daycare:** | |
| **Address:** | |
| **Phone number** | **Years attended:** |
| **Grade Level** | **Would you like services in school?** |
| **Does your child have an IEP?** | **Does your child have behaviors at school?** |

**History of ABA therapy**

|  |
| --- |
| **Has your child received previous ABA?** |
| **Provider Agency:** |
| **BCBA’s name:** |
| **Hours of Services:** |
| **Dates of services:** |

**Other Therapies**

|  |  |  |
| --- | --- | --- |
| **Does your child receive other types of therapy (e.g., speech, OT, PT, etc.)** | | |
| **Therapy** | **Location** | **Minutes per week** |
| **Speech** |  |  |
| **Occupational Therapy** |  |  |
| **Physical Therapy** |  |  |
| **Other:** |  |  |
| **Other:** |  |  |

**Questions for Parents**

|  |
| --- |
| Reasons for wanting ABA therapy: |

|  |
| --- |
| Ideal Schedule |

|  |
| --- |
| Does your child have any behavioral concerns: |

|  |
| --- |
| Your child’s likes/dislikes |

|  |
| --- |
| What are your goals and expectations: |

|  |
| --- |
| Any additional information that would be beneficial to know about your child: |

The undersigned hereby acknowledge that the information contained in this application is accurate in all respects:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Parent’s printed name:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Parent’s signature & Date

Authorization to Release of Client Records

Client’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_

Date of request: \_\_\_\_\_\_\_\_\_\_\_ Valid Through \_\_\_\_\_\_\_

I understand the medical records released are confidential. I understand that the specified information to be released may include by is not limited: history, medical diagnoses, and treatment outcomes as it pertains to past and present symptoms related to treatable medical diagnoses within this profession.

This release will remain in effect for two (2) years from the date of request. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I authorize Weathers Developmental & Behavioral Therapy to exchange, release, or obtain information both verbally and in written form.

I hereby authorize Weathers Developmental & Behavioral Therapy to:

\_\_\_ Exchange with \_\_\_\_ Release to \_\_\_\_\_ Obtain from

Organization or Individual receiving/communicating the information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Name of Organization or Provider

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Address (including city, state, zip) Phone Number

Information to be released or accessed:

\_\_\_\_\_ Treatment Plan(s) \_\_\_\_ Consent/HR form(s) \_\_\_\_\_ Assessment

\_\_\_\_\_ Medical Records \_\_\_\_ Clinical Records (SP, OT, PT, or evaluation)

\_\_\_\_\_ Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  
Parent Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  
Kasi Weathers, BCBA/Owner of WDB Date