Oxford Recovery Center - Consent for Services

Date: _____

First name: _____

Last name: _____

Date of Birth: _____

Welcome to Oxford Recovery Center! This consent form contains important information about our professional services and our policies. This form outlines the rights and responsibilities of the clients (the child served and his/her family) and of Oxford Recovery Center. By signing this document, you are indicating that you consent for yourself or your child to receive assessment and treatment services and that you are in agreement with our policies.

Assessment and Treatment Services

I have been informed by **Dr. Christian Bogner**, Medical Director about the services provided by Oxford Recovery Center.

• I consent for my child / myself to receive the assessment and treatment services provided by Oxford Recovery Center.

Confidentiality

I understand that all services provided by Oxford Recovery Center are confidential. Oxford Recovery Center is required to obtain my informed written consent before releasing any information except where required by legislation or directed by the courts. Examples of such exceptions may include reporting suspicion of child abuse or a child in need of protection, informing someone in a position of authority if a client is in imminent danger of harming themselves or others, or providing information as directed by the courts through subpoena, search warrant, or other legal order.

Assessment and Treatment Services

I understand and acknowledge that Dr. Christian Bogner is board-certified in obstetrics and gynecology. I understand that his recommendations and approaches to disease do not necessarily reflect the views of the American Academy of Pediatrics, American Medical Association or other organizations. I also understand that my insurance will not cover the consultation and other services provided by Oxford Recovery Center. I am aware and understand that I should obtain a second opinion from my primary care physician and/or pediatrician with any of the testing or therapies offered by Oxford Recovery Center.

Consent for Medical Treatment

I give consent to Oxford Recovery Center its staff, physicians and other practitioners (the "Practice") to provide and perform such medical care, tests, procedures, and other services that are deemed necessary or beneficial by the Practice for the patient's health and well-being.

Patient Involvement in Care and Services

- I understand that my child has the right to participate in the planning process for his/her care and may refuse services.

Family Participation

My participation in the treatment program is essential for my child's learning. I will discuss with the parent trainer to identify the best way I can be involved in my child's program, taking into account all aspects of my family. I understand that I will have to participate in the following ways:

- Attending regularly scheduled appointments
- Helping my child to generalize skills learned through the treatment program

I understand that the involvement of all family members will aid in generalization of learned skills and will increase the likelihood of positive outcomes for my child. I can discuss with the Clinical Supervisor how to best have family members involved.

- I understand that if I have questions or concerns regarding my child's ability to generalize skills, I may ask my child's therapist to provide me with additional training.
- I understand that, upon request, Oxford Recovery Center will provide additional information, guidance and educational materials to help me best support my child's growth and development.

Food Reinforcers

I understand that, when appropriate, food may be used a reinforcer. I will keep Oxford Recovery Center updated on any allergies my child may have. I will also refrain from allowing my child

access to certain foods that are being used specifically for treatment purposes. This will increase the likelihood that they will serve as powerful reinforcers.

Discharge Process

ORC reserves the right to discontinue services or discharge individuals from their services under the following conditions:

1. Individual achieves all of his or her established goals and the parent/caregiver/individual agrees that graduation from services is warranted
2. Parent/primary caregiver/individual refuses to follow the mutually agreed upon treatment plan after repeated reminders and attempts to resolve barriers to implementation
3. Individual ages out of coverage (e.g., at the individuals 28th birthday and/or no longer enrolled in school). Note: this applies to ABA therapy through insurance and Medicaid only; other rules vary based on funding source.
4. Individual is not achieving the goals of treatment despite exhaustion of all known interventions, procedures, and research-based strategies.
5. ORC ABA staff become aware of circumstances (e.g., drug abuse, illegal activities, hostile behavior of caregivers) that may place them at risk
6. Individual, parent, or guardian decides to terminate services for any reason

If at any time ORC or the parent/guardian/individual determines that services must be terminated, we will notify the other party immediately and establish a discharge plan to be provided to the parent/guardian/Individual within 14 business days. If a client is discharged from ORC ABA center, it is the policy of our agency to provide a list of other providers and professionals in the area with the background and expertise to provide effective support services to the client and their family. Our staff does not provide services or recommendations outside our area of expertise.

ORC. will not turn down a family for coverage nor will we discharge or discontinue treatment on the basis of race, creed, sexual orientation, or socio-economic characteristics.

Benefits and Risks

I understand that the possible benefits of our participation in this program are as follows:

• My child's mental age, social, and adaptive functioning may improve,

• I may become a more effective teacher for my child than I am now,

• Because I do not need to be present during all therapy hours, I may have more time to attend to my own or family needs,

• Information collected on my child may lead to the improvement of services for other children with autism or related disorders.

I understand that although the treatment provided is intended to be beneficial and has helped children like mine in the past, participation may involve some of the following risks or discomforts for my child:

• It is possible that the program may not help my child to improve his/her abilities,

• My child may present some behavior problems during or after therapy hours,

• My child may experience some distress (e.g., crying) when the behavior specialists are teaching new skills such as sitting on the chair or sitting in front of a new therapist.

• My child may experience adverse side effects from medications

Contacting Oxford Recovery Center

• I understand that staff of Oxford Recovery Center may not always be readily available by phone or email, however, I acknowledge that attempts will be made to respond to any messages will be returned within one business day.

• I understand that if I am not able to wait for the staff of Oxford Recovery Center to respond to my message, I should contact my pediatrician and/or family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. I agree to call 911 in the event of any life threatening emergencies.

• I understand that emails are not a confidential way to contact Family First and that personal information contained in emails may be accessible to third parties.

- I understand that if I have concerns or complaints about services or treatment, I should contact Elizabeth Terry, RN at elizabeth@oxfordrecoverycenter.com or **(248)486-3636**.

Minors and Parents/Guardians

• I understand that if a client is under the age of 18, parents/guardians have the right to access youth files.

• I understand that Oxford Recovery Center recommends that both parents/guardians provide consent for assessment and treatment and that in some cases consent from both will be required.

Confidentiality

• As discussed above, I understand that my child's information will be confidential and will not be shared with others unless required by law.

• I understand that should I wish my child's information to be shared with other practitioners or educators, I will need to complete a Request/Authorization to Release Confidential Records and Information stating exactly what information is to be shared.

• I understand that Oxford Recovery Center may be required to share some information about my child with others for professional reasons, such as billing, scheduling, or answering service. I understand that all of these individuals will be held to the same confidentiality expectations as Oxford Recovery Center.

MY SIGNATURE BELOW INDICATES THAT I HAVE READ THIS CONSENT FORM AND AGREE TO ITS TERMS. ALL OF THIS INFORMATION HAS BEEN EXPLAINED TO ME, I HAVE BEEN GIVEN AN OPPORTUNITY TO ASK QUESTIONS, AND I HAVE HAD ALL OF MY QUESTIONS ANSWERED.

Parent/Guardian Printed Name Date

Parent/Guardian Signature Date

Child/Minor Date