CONSENT & AUTHORIZATION TEMPLATES

Consent to Treatment & Service Agreement

Signed once, before the assessment, by a person with the legal authority to consent for the client.

Client name _____ **Date of birth** _____

Parent / guardian completing this form _____ **Relationship to client** _____

CONSENT TO ASSESS AND TREAT

I request and authorize [PRACTICE NAME] to provide applied behavior analysis services to the client named above. I understand that services begin with an assessment conducted by a [BCBA / licensed behavior analyst], that the assessment produces a written treatment plan, and that services are delivered by behavior technicians under that analyst's supervision.

I understand that the assessment and treatment plan are clinical recommendations, that the amount of service ultimately delivered may be limited by my health plan's authorization, and that no specific outcome has been promised to me.

AUTHORITY TO CONSENT

I certify that I am the client's parent, legal guardian, or otherwise legally authorized to consent to this client's health care, and that no court order limits my authority to do so. If that changes, I will notify [PRACTICE NAME] in writing within [NUMBER] days and provide the documentation establishing who may consent.

SERVICES, SETTING, AND PARTICIPATION

Services will be delivered in the following setting(s): [HOME / CENTER / SCHOOL / COMMUNITY / TELEHEALTH]. I understand that caregiver participation is a clinical component of the program and that my health plan may require documentation of that participation to continue authorizing services.

ATTENDANCE AND CANCELLATION

Consistent attendance is required for the program to work and for authorizations to be maintained. I understand [PRACTICE NAME]'s attendance expectations, including that cancellations should be made at least [NUMBER] hours in advance where possible, and that repeated missed sessions may result in a change to the schedule or discharge from the program.

BILLING AND ASSIGNMENT OF BENEFITS

I authorize [PRACTICE NAME] to bill my health plan for services provided and to release the clinical information the plan requires to process authorizations and claims. I assign to [PRACTICE NAME] the benefits otherwise payable to me for these services, and I remain responsible for amounts my plan does not pay.

WITHDRAWING CONSENT

I may withdraw this consent at any time by notifying [PRACTICE NAME] in writing. Withdrawal takes effect when received and does not apply to services already provided or to disclosures already made in reliance on it.

Parent / guardian signature	Printed name	Date
Relationship to client	Phone	Email
[PRACTICE NAME] representative	Title	Date

CONSENT & AUTHORIZATION TEMPLATES

Acknowledgement of Privacy Practices

A one-page acknowledgement that the notice was provided. Acknowledgement only — never a condition of scheduling.

Client name _____ **Date of birth** _____

ACKNOWLEDGEMENT

I acknowledge that I have been provided with a copy of the Notice of Privacy Practices of [PRACTICE NAME], which describes how health information about the client named above may be used and disclosed, and how I can get access to that information. I understand that [PRACTICE NAME] may update the notice and that the current version is available at [WEBSITE / LOCATION] or on request.

_____ Parent / guardian signature

_____ Printed name

_____ Date

_____ Relationship to client

_____ Phone

_____ Email

FOR STAFF USE — IF THE ACKNOWLEDGEMENT WAS NOT OBTAINED

Document the good-faith effort made to obtain this acknowledgement and why it was not obtained. Services are not withheld for a missing acknowledgement.

Effort made and reason not obtained

_____

Staff name _____ **Date** _____

CONSENT & AUTHORIZATION TEMPLATES

Communication Consent — Email, Text, and Voicemail

Collected at first contact, before any automated reminder or follow-up runs. Keep the record of when and how it was given.

Client name _____

Parent / guardian name _____

Mobile number for texts _____

Email address _____

WHAT WE WILL SEND

With your permission, [PRACTICE NAME] will contact you about this client's care: appointment reminders and scheduling, requests for documents needed to start or continue services, insurance and authorization updates, and occasional program announcements. Message frequency varies with what is happening in your child's intake and care.

CHOOSE HOW WE MAY REACH YOU

- ☐ Text message (SMS/MMS) to the mobile number above
- ☐ Email to the address above
- ☐ Detailed voicemail at the number above (rather than a request to call back)
- ☐ Automated appointment reminders through our scheduling system

WHAT YOU SHOULD KNOW

- Email and text are not fully secure. Messages may be seen by anyone with access to your device or account, and information about your child's care may appear in them.
- Standard message and data rates from your carrier may apply. [PRACTICE NAME] does not charge for these messages.
- You can stop text messages at any time by replying STOP, or get help by replying HELP. You can stop emails using the unsubscribe link or by telling us.
- You can change or withdraw this consent at any time by contacting us at [PHONE] or [EMAIL].
- Consenting to text messages is not a condition of receiving services. We will reach you another way if you prefer.

Parent / guardian signature	Printed name	Date
Relationship to client	Phone	Email

> Practices sending automated texts in the United States also register their messaging campaign with the carriers (A2P 10DLC). The opt-in language above, the STOP/HELP instructions, and the record of when consent was given are what that registration asks you to keep.

CONSENT & AUTHORIZATION TEMPLATES

Financial Responsibility & Benefits Acknowledgement

Given after verification returns real numbers, not before. It puts the family's actual cost-share in writing.

Client name | **Date of verification**

Health plan | **Member ID**

WHAT VERIFICATION FOUND

Network status | **Deductible / amount met**

Coinsurance or copay | **Out-of-pocket maximum**

Authorization required | **Visit or hour limits**

ACKNOWLEDGEMENT

I understand that the amounts above come from a benefits verification performed with my health plan on the date shown, that a verification is a quote of benefits and not a guarantee of payment, and that the plan determines what it will pay when a claim is processed. Eligibility, deductible status, and authorization requirements can change.

I understand I am responsible for deductibles, copays, coinsurance, and any services my plan does not cover, including services provided after an authorization expires or is denied. [PRACTICE NAME] will tell me before continuing services that my plan has stopped covering.

PRIVATE-PAY RATES AND FEES

Assessment rate | **Direct therapy rate (per hour or unit)**

Supervision rate | **Late-cancellation / no-show fee**

OTHER COVERAGE

I have disclosed all health coverage this client has, including any secondary or supplemental plan and any coverage through another parent or guardian. I will notify [PRACTICE NAME] within [NUMBER] days of any change in coverage.

Parent / guardian signature | Printed name | Date

Relationship to client | Phone | Email

CONSENT & AUTHORIZATION TEMPLATES

Authorization to Use or Disclose Health Information

The release that lets you trade records with the diagnosing clinician, the pediatrician, the school, and other therapies. One per outside party.

Client name _____ **Date of birth** _____

WHO MAY EXCHANGE INFORMATION

I authorize [PRACTICE NAME] and the party named below to exchange the health information described below.

Other party (person or organization) _____ **Relationship / role** _____

Address _____ **Phone and fax** _____

DIRECTION OF THE EXCHANGE

- ☐ Release information from [PRACTICE NAME] to the party named above
- ☐ Obtain information from the party named above
- ☐ Both — exchange information in either direction for coordination of care

INFORMATION COVERED

- ☐ Diagnostic evaluation and testing results
- ☐ Treatment plans, progress reports, and session data
- ☐ Referrals, orders, and prescriptions
- ☐ Educational records, including the IEP, IFSP, or 504 plan
- ☐ Records of other therapies (speech, occupational, physical)
- ☐ Other: _____

PURPOSE, EXPIRATION, AND YOUR RIGHTS

Purpose of this authorization: [COORDINATION OF CARE / INSURANCE AUTHORIZATION / OTHER]. This authorization expires on [DATE] or [EVENT], and if no date is entered it expires [NUMBER] months from signature.

I may revoke this authorization at any time by writing to [PRACTICE NAME] at [ADDRESS]. Revocation does not apply to information already released in reliance on it. Treatment, payment, and enrollment are not conditioned on my signing, except where the information is needed to determine whether services can be authorized or paid. Information released may no longer be protected by federal privacy rules once it reaches the receiving party.

> Some categories of information — mental health notes, substance use records, HIV status, genetic testing — carry extra rules that vary by state and may require a separate signature or initials. Have your compliance reviewer confirm what your state requires before using this form.

Parent / guardian signature _____ Printed name _____ Date _____

Relationship to client _____ Phone _____ Email _____