Spectrum of Grace
Address: 4425 Plano Pkwy, Suite 403, Carrollton, TX 75010
Phone: ***469-900-8063*** **Email:** adrenastreetz@spectrumofgrac.org

1. CLIENT INFORMATION & DEMOGRAPHICS

Child's Name: _____
DOB: _____ **Age:** _____ **Sex:** _____
Parent/Guardian Name: _____
Relationship to Child: _____
Address: _____
Phone: _____ **Email:** _____
Primary Care Physician: _____
PCP Phone: _____**Fax:** _____

Insurance Plan: TMHP / Medicaid
Member ID: _____

I certify that I am the legal guardian and authorized to consent to treatment.
Signature _____
Date _____

2. CONSENT FOR ABA TREATMENT & ASSESSMENT

I understand that Applied Behavior Analysis (ABA) is an evidence-based treatment focused on improving socially significant behavior, communication, adaptive skills, safety, and independence. Treatment may include assessments, behavior intervention planning, direct therapy, caregiver training, data collection, and collaboration with medical and educational professionals.

I understand:
• Treatment plans are individualized and medically necessary.
• Progress is monitored and treatment may be modified.
• I may withdraw consent at any time.
• Participation is voluntary.
I give consent for: ✔️Initial assessments and ongoing reassessments
✔️Development and implementation of ABA treatment plans
✔️Parent/caregiver training
✔️Collaboration with PCP, specialists, schools, and TMHP when needed for treatment

Signature _____
Date _____

3. MEDICAL NECESSITY & PHYSICIAN REFERRAL ACKNOWLEDGEMENT

I understand that TMHP requires documentation of Autism diagnosis and physician referral for ABA services. I agree to provide necessary documentation and authorize Spectrum of Grace to coordinate with my child's physician regarding treatment needs and medical necessity documentation.

Signature _____ **Date** _____

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4. HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge receipt of Spectrum of Grace's Notice of Privacy Practices. I understand how my child's health information may be used and disclosed for treatment, billing, and healthcare operations, and that I may request restrictions or revoke consent in writing.

Signature _____ **Date** _____

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5. AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

I authorize Spectrum of Grace to release and exchange treatment and clinical information with: ☐ Primary Care Physician ☐ Specialists ☐ School District ☐ TMHP ☐ Other _____

This authorization is voluntary and may be revoked in writing. Revocation does not apply to information already released.

Signature _____ **Date** _____

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6. FINANCIAL RESPONSIBILITY & CONSENT TO BILL TMHP

I understand services are billed to TMHP/Medicaid. I understand: • I am responsible for providing accurate insurance information. • I may be responsible for any non-covered services. • Missed appointment policies may apply according to clinic policy.

I authorize Spectrum of Grace to bill TMHP for ABA services rendered and to receive payment directly.

Signature _____ **Date** _____

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7. TELEHEALTH CONSENT (We Provide Telehealth Services)

I understand telehealth may be used for: • Parent/caregiver training • Client sessions when clinically appropriate • Assessments when appropriate

I understand: • Technology risks exist including interruption or confidentiality limitations.
• Participation requires stable internet and private environment.
• I may refuse or discontinue telehealth at any time.

Signature _____ **Date** _____

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8. PHOTO/VIDEO CONSENT (OPTIONAL)

Photos/videos may be used for clinical data, treatment planning, and supervision only. No images will be shared publicly without separate authorization.

☐ I consent ☐ I DO NOT consent

Signature _____ **Date** _____

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9. EMERGENCY & CRISIS CONSENT

I understand Spectrum of Grace may implement safety procedures if my child exhibits dangerous or self-injurious behaviors, including crisis intervention strategies aligned with the behavior plan. In the event of medical or psychiatric emergency, 911 may be contacted.

Signature _____ **Date** _____

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10. CLIENT RIGHTS & RESPONSIBILITIES ACKNOWLEDGEMENT

I understand I have the right to: • Be treated with dignity and respect
• Participate in treatment planning
• Receive care in the least restrictive manner
• File complaints or grievances without retaliation

I understand my responsibilities include participation in treatment, attendance, and communication with staff.

Signature _____ **Date** _____

FINAL CONSENT SUMMARY SIGNATURE PAGE

By signing below, I acknowledge that I have read, understood, and agree to the contents of this ABA consent packet and authorize Spectrum of Grace to provide ABA services to my child.

Child's Name: _____ Parent/Guardian Printed Name: _____ Signature _____ **Date** __ ***Witness/Staff*** ___ ***Date*** _____
