FULL CIRCLE PEDIATRIC SOLUTIONS
P: 701-478-0221
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4725 AMBER VALLEY PARKWAY, SUITE B,
FARGO, ND 58104
FULLCIRCLEPEDIATRIC.COM

CONSENT FOR APPLIED BEHAVIOR ANALYSIS SERVICES

This document contains important information about Full Circle Pediatric Solutions applied behavior analysis (ABA) professional services and practice polices. The 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 Guidelines for Responsible Conduct of Behavior Analysts.

Treatment Team and Goals

I, _____, agree to have my child/dependent, _____, participate in applied behavior analysis (ABA) assessment and/or treatment services provided by Full Circle Pediatric Solutions.

☐ I understand that my child/dependent is the primary client and that services will be designed primarily for their benefit. I understand any other individuals or agencies (e.g., family, day-care providers, school professionals) are considered secondary clients.

☐ I understand I can ask for clarification prior to signing this document and at any time during service delivery to ensure my full participation.

☐ I understand that a record of the treatment will be maintained, and this record is available to me in written form upon request.

☐ I understand that assessment, treatment, and supervision may be completed by a BCBA, BCaBA, or RBT employed through Full Circle Pediatric Solutions.

Assessment

☐ I understand that the beginning of services (3-8 sessions) will include functional assessment and/or functional analysis activities that are designed to provide information critical to the development of effective treatment procedures.

Treatment

☐ I understand the subsequent services will be focused on development of and implementation of instructional procedures and/or a behavior intervention plan.

Evidence-Based Treatment

☐ I understand that behavior analysts are ethically obligated to provide treatments that have been scientifically supported as the most effective for the client and must refrain from implementing non-evidence-based treatments.

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Reinforcers and Motivation

☐ I understand and agree that Full Circle Pediatric Solutions may utilize external reinforcers as a consequence to facilitate skill acquisition and appropriate behavior.

Participation

☐ I understand that 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, Full Circle Pediatric Solutions reserves the right to revisit and reconsider the appropriateness of services.

Confidentiality

☐ I understand the fact that my child/dependent receives any services is protected and private information.

☐ I understand that Full Circle Pediatric Solutions may release information without my prior consent if ordered by a court of law.

☐ I understand that providers are mandated reporters and are legally required to report suspected occurrences of child abuse or neglect.

☐ I understand that Full Circle Pediatric Solutions may photograph, audiotape, or videotape assessment and/or treatment sessions for assessment, program evaluation, supervision, and training purposes.

☐ I understand that if Full Circle Pediatric Solutions plans to use the recorded material for marketing or workshop events available to the general public, I will be informed and reserve the right to consent or refuse to consent to the use of these recordings for those purposes. If the assessment or treatment involves formal research that goes beyond normal evaluation or clinical procedures, I reserve the right to consent or refuse to participate.

Liability Policies

☐ I understand that at no time may I leave my child unattended with Full Circle Pediatric Solutions in the home or community. If I need to leave during a session (e.g., in case of an emergency), I have the right to cancel the session.

☐ I understand that Full Circle Pediatric Solution employees are not allowed to transport any family members in their vehicle.

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Scheduling

☐ I understand that schedule changes require a 6-week notice. If a schedule change with less than 6-week notice occurs, I understand that an effort will be made to provide consistent intervention but that there may be a lapse in service.

Cancellation and Termination

☐ I understand I reserve the right to refuse, at any time, the treatment that is being offered.

☐ I understand that Full Circle Pediatric reserves the right to terminate services and will provide the client and third party with a list of qualified behavior analysis professionals to contact regarding receiving services.

☐ I understand that I am responsible for adhering to the Attendance/Cancellation Policy set forth in a separate document.

Payment for Services

☐ I understand that I am responsible for adhering to the payment arrangements set forth in a separate document.

Dual Relationships

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

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I may request a copy of Full Circle Pediatric Solutions current professional credentials upon request. In addition, any grievance that I have about Full Circle Pediatric Solutions performance can be reported to the Concern Reporting Form located on the clinic website (http://fullcirclepediatric.com/). Grievances may also be directed to:

The Behavior Analyst Certification Board (BACB)
Behavior Analyst Certification Board, Inc
Disciplinary Matters 8051 Shaffer Parkway
Littleton, Colorado 80127

These policies 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

_____ _____
Britney Bachmeier, Psy.S., NCSP, BCBA, LABA Date
Owner/Behavior Analyst
Full Circle Pediatric Solutions
BCBA Certificate #L-21