6317 Highway 329
Crestwood, KY 40014

PHONE
502.384.0910

FAX
502.384.0908

Child's Name: _____ Child ID #: _____

Consent for Evaluation & Treatment, Client Rights and Commitments

Client/parental rights include but are not limited to the following:

1. The right to deny evaluation or treatment or disagree with the professional's clinical judgment.
2. The right to request a second opinion or alternate agency/clinician.
3. The right to all medical records kept by The Chatter Box, LLC pertaining to your child.
4. The right to assist in the establishment of goals, treatment strategies, and client outcomes.
5. The right to be consistently updated regarding progress and concerns.
6. The right to confidentiality of all medical records.

This agency is committed to all clients:

1. Communication and collaboration with the family and The Chatter Box is essential in the evaluation and treatment process.
2. Professionals will work with the family to make scheduling accommodating.
3. All professional knowledge and resources available will be used for the benefit of the client.
4. Respect for the client and family will be shown at all times.
5. An initial evaluation report, six month report, weekly progress notes, and discharge summaries will be provided to the family.
6. Reports and/or additional information will be released only to agencies/professionals documented on the release of information.
7. The Chatter Box, LLC professionals will make every attempt to be on time and attend all treatment sessions. Any cancellations will be communicated in advance. If therapy is missed, the professional will try to work with the family to reschedule appointments.
8. The Chatter Box, LLC will use client information released by parents/caregivers for payment/billing purposes.

As The Chatter Box, LLC professionals are committed to all families/caregivers, we encourage you to be committed to The Chatter Box

1. Allow staff (marketing) to schedule appointments or cancellations. Please call in advance to cancel therapy. More than three "no shows" for appointments, professional will discharge services.
2. Please commit to consistent follow through with home program activities and strategies in the natural environment in order to maximize the outcomes of treatment and development of your child.
3. Please be involved in therapy and ask questions to clarify and gain understanding of your child's development.
4. Please keep the professional informed of any changes in address, locations of treatment, phone numbers, and caregiver of the child.
5. Please call to cancel or reschedule treatment sessions if your child is ill.

I have read and agree with the rights and commitments presented above.

_____ _____
Client/Personal Representative Signature Date

_____ _____
Therapist Date