



CONSENT TO TREATMENT

I, _____, agree to have my child _____, assessed and treated by Discovery Behavior Solutions (DBS) a behavioral health provider. I understand that the service that will be provided to my child is applied behavior analysis (ABA). Applied Behavior Analysis grew out of the scientific principles of learning and behavior. Behavior analysis has proven to be a particularly effective learning tool for helping children with autism or developmental delays acquire and maintain new skills. Furthermore, I am aware that the individual providing treatment for my child is board certified by the Behavior Analyst Certification Board (BACB).

If the child is under the age of 18 years old or unable to consent to treatment, I attest that I have legal custody or I am legally authorized to initiate and consent to treatment for the child named above. If the child is 13 years of age or older and able to sign for treatment, they must sign as well.

I am aware that any consent given as set forth in this document may be withheld or withdrawn at any time verbally or in writing.

I am aware that DBS staff are mandated reporters and that if there is suspicion of abuse or neglect or if the child is a safety risk to themselves or others this will need to be reported to the proper authorities.

Legal Guardian First and Last Name Date

Legal Guardian Signature Date

Client First and Last Name Date

Client Signature (if applicable) Date