ABA Services and Supports Agreement and Consent

This agreement, dated _____ (day/month/year), is between:

Name of Parent/Guardian: _____

Address: _____

_____

_____

and

ABA Services and Supports (regional)
Chedoke site, Empire Building
McMaster Children's Hospital
Box 2000, Hamilton ON
L8N 3Z5

ABA Services and Supports (local)
_____
_____
_____
_____

This agreement covers the terms and conditions under which treatment will be provided for ABA services and Supports for:

Child's name: _____

Date of Birth: _____

- ❑ I have read the 'ABA Services and Supports: Parent Information Package' and agree that my child and I will participate in this service.
- ❑ I agree that my child's records may be used for program evaluation or teaching purposes, if all personal identification information is removed.
- ❑ I do not want my child records used for program evaluation or teaching purposes.
- ❑ I agree to ensure my child (and I, as applicable) arrives on time and attends all scheduled sessions and required meetings. If I/my child is unable to meet this requirement, I will contact my ABA service provider as soon as possible. I understand that if I fail to do so, ABA services may be canceled.

Parent/Caregiver Signature	Date
Clinical Leader/Manager Signature	Date
Clinical Supervisor Signature	Date

Copy: Parent/Guardian, Health records, Agency file

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dt/April 11, 2012