EVALUATION CENTER FOR LEARNING
Jennifer Edidin, Ph.D.
874 Green Bay Road, Suite 380
Winnetka, IL 60093
(847) 441.4433

Patient's Name: ______________________ Date of Birth: ______________________

CONSENT FOR ASSESSMENT

- I understand that by signing this Consent for Assessment form, I have read the Office Policies (included in a separate document), received answers to any questions that I have related to the assessment process, consent to the assessment, and agree to abide by the policy terms during our professional relationship.
- I understand that promises have not been made about the results of this assessment and that the results may differ from expectations.
- I understand that I may stop the assessment and revoke my consent in writing at any time; however, if I choose to do this, I will be responsible for payment for all services rendered until that time at Dr. Edidin's hourly rate.
- I understand that I must call to cancel my/my child's appointment at least 3 days before the time of the appointment otherwise my credit card will be charged 50% of the rate on the credit card provided.
- I understand that I am responsible for payment for all services rendered by Dr. Edidin.
- I understand that Dr. Edidin does not participate in any insurance plans. Once payment is received, Dr. Edidin will provide me with a superbill that I can submit to insurance.
- I understand that if my account is not paid within 60 days of the statement date and I have not made alternative payment arrangement, Dr. Edidin will charge my credit card on file for the balance listed on the statement as well as any fees that are incurred to process the credit card payment.
- By signing this form, I indicate that I am the legal guardian of the patient named above, and I am authorized to provide informed consent for treatment.
- I consent/assent to take part in the assessment by the clinician(s) at the ECFL.

____ _________________
Signature of Patient or Recipient of Service (if over 12 years old) Date

____ _________________
Signature of Patient or Recipient of Service (if over 18 years old) Date

____ _________________
Signature of Parent or Guardian (if under 18 years old) Date

____ _________________
Printed Name of Parent or Guardian Date

COMMUNICATION POLICIES

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Please initial next to the specific information that you would like to receive electronically. There is risk involved in electronic communication; consequently, Dr. Edidin asks that you do not provide sensitive information in an email. Your initials indicate that you agree to assume all risks involved in electronic communications.

_____ Scheduling

_____ Final Reports (encrypted)

_____ Other Communication

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Patient's Name________________________________ Date of Birth _____________

CONSENT FOR RELEASE OF INFORMATION TO PEDIATRICIAN

I hereby authorize the Evaluation Center for Learning (ECFL) to send a copy of the report to my child's pediatrician.

Clinician's Name: ____

Clinician's Address: ____

Clinician's Phone Number ______________________ Clinician's Email Address ______________________

I understand that my decision to sign this form is entirely voluntary and I may refuse to sign this form. I have the right to inspect the report to be disclosed. If I do not sign this form, the information will not be disclosed other than by court order or as requested by law. I understand that I may revoke this consent in writing at any time. Any such revocation will have no effect on disclosures made prior to the date the revocation is received

____ _________________
Signature of Patient or Recipient of Service (if over 12 years old) Date

____ _________________
Signature of Parent or Guardian (if under 18 years old) Date

____ _________________
Printed Name of Parent of Guardian (if under 18 years old) Relationship to Patient

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Patient's Name________________________________ Date of Birth _____________

CONSENT FOR RELEASE OF INFORMATION TO REFERRING AND TREATING CLINICIANS
(e.g., therapist)

I hereby authorize the Evaluation Center for Learning (ECFL) to send a copy of the report to my child's treating clinician.

Clinician's Name: ____

Treating Clinician: Yes ☐ No ☐

Referring Clinician: Yes ☐ No ☐

Clinician's Address: ____

Clinician's Phone Number ______________________ Clinician's Email Address ______________________

I understand that my decision to sign this form is entirely voluntary and I may refuse to sign this form. I have the right to inspect the report to be disclosed. If I do not sign this form, the information will not be disclosed other than by court order or as requested by law. I understand that I may revoke this consent in writing at any time. Any such revocation will have no effect on disclosures made prior to the date the revocation is received

____ _________________
Signature of Patient or Recipient of Service (if over 12 years old) Date

____ _________________
Signature of Parent or Guardian (if under 18 years old) Date

____ _________________
Printed Name of Parent of Guardian (if under 18 years old) Relationship to Patient

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CONSENT TO SEND QUESTIONNAIRES TO TEACHERS AND/OR SCHOOL STAFF

I hereby authorize the Evaluation Center for Learning (ECFL) to send questionnaires to my child's school to collect information about my child's functioning in that setting. Dr. Edidin may send questionnaires to my child's teacher(s) and/or other staff members who can provide information about my child's functioning at school. I understand that my decision to sign this form is entirely voluntary.

Name of School: ____

School Address ____

School Phone Number _________________

Teacher Name: ____________________________ Teacher Email Address ___________________

Teacher Name: ____________________________ Teacher Email Address ___________________

Staff Name: ______________________________ Staff Email Address ______________________

This consent is valid for one year from date OR until ________________ (date).

____ __________________
Signature of Patient or Recipient of Service (if over 12 years old) Date

____ __________________
Signature of Parent or Guardian (if under 18 years old) Date

____ __________________
Printed Name of Parent of Guardian (if under 18 years old) Relationship to Patient

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HIPAA ACKNOWLEDGEMENT

This form serves as acknowledgement that you have been informed of your rights under The Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, a copy of which has been given to you, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information by the end of this session. Your signature below serves as acknowledgement that you have received a copy of the HIPAA Notice Form (included in a separate document) described above.

______________________________________ ________________________
(Parent or Student 18 years old or older) (Date)