Neurodiversity Consultants LLC
6810 Emlen Street
Philadelphia, PA 19119
www.NeurodiversityConsultants.com
info@NeurodiversityConsultants.com
215-356-8418

CONSENT TO TREAT

Client Name:	**Client DOB**:
Statement of Consent: I have discussed my rights to treatment via consultation services with Neurodiversity Consultants LLC, and having been provided due consideration, I give my consent and authorization for assessment, support services, and/or other consultation as discussed. I understand that I have the right to refuse any services, and that I will not be discriminated against on the basis of race, national origin, sex, sexual orientation, age, religion, or disability. With my signature, I am verifying that I have been informed of the benefits, risks, and alternative treatment methods, as well as the consequences of not receiving treatment. I understand that a 24-hour cancellation policy is in effect, and that myself or my funding entity may be charged for missed appointments, barring acknowledged emergencies. I also understand that I or my funding entity may be invoiced for reasonable consultant travel time and indirect time for collaboration with other team members when necessary for the provision of proper support. I hereby consent that Neurodiversity Consultants LLC has my permission to invoice the funding entity below for consultation services. I will receive copies of any invoices upon request. I authorize my funding entity below to pay for invoices submitted, and I realize that I am responsible to arrange payment for invoices not paid within 60 days. **Funding Entity**:	
Acknowledgement of Consent: I understand that I may revoke my consent in writing at any time. This consent is valid from the signature date below, and is revoked following the cessation of services.	
Signature of Client (if 14 years of age or older, and if capable of meaningfully signing):	**Date**:
Parent/Guardian signature: Relationship to Client:	**Date**:
Neurodiversity Consultants LLC Signature:	**Date**:

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CONSENT TO RELEASE INFORMATION

Client Name:	**Client DOB**:
Statement of Consent: I authorize Neurodiversity Consultants LLC and the entity listed below to *share* and/or *receive* materials or content (verbally, electronically, and/or in writing) that are relevant my services, treatment, supports, education, and/or medical treatment with Neurodiversity Consultants LLC and/or the entity listed below:	
Acknowledgement of Consent: I understand that I may revoke my consent in writing at any time. This consent is valid from the signature date below, and is revoked following the cessation of services.	
Signature of Client (if 14 years of age or older, and if capable of meaningfully signing):	**Date**:
Parent/Guardian signature: Relationship to Client:	**Date**:
Neurodiversity Consultants LLC Signature:	**Date**:

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CLIENT RIGHTS FORM

Consultation services provided by Neurodiversity Consultants LLC afford individuals the following rights:

- The right to be treated with dignity and respect.
- The right to choose services based upon accurate information.
- The right to ask questions and get answers about services.
- The right to participate fully in decisions about services.
- The right to request changes in services.
- The right to receive services in the least restrictive setting.
- The right to refuse services, unless ordered by the Court to participate.
- The right to have one's family involved in services, or to refuse family participation.
- The right not to be subjected to verbal, physical, sexual, emotional, or other abuse.
- The right to make complaints, have them heard, and get a response without mistreatment.
- The right to file a grievance if not satisfied with the response to a complaint.
- The right to be assisted by an advocate of one's choice.
- The right to review one's records, unless doing so may be deemed harmful.
- The right to privacy of records, except in emergencies and Court orders.
- The right to exercise all civil and legal rights afforded to citizens.
- The right not to be discriminated against.

Making a complaint:

- Anyone who has witnessed, or has knowledge of, a violation of a client's rights can bring the matter to the Neurodiversity Consultants LLC's attention.
- You will be asked to give details about what happened, when it happened, where it took place, and who was involved. You should not be threatened, punished or forced to cease services just because you make a complaint.
- Neurodiversity Consultants LLC will let you know promptly what we will do to address the issue and try to prevent it from occurring in the future. However, we may need to investigate further by asking questions of those connected to the complaint, and we will attempt to schedule a time to meet with you as soon as possible to discuss subsequent findings and recommendations.
- The findings and recommendations of an investigation may need to be sent to the Deputy Health Commissioner in Philadelphia as required within 30 days. If so, a copy will also be sent to you and to the those accused of violating your rights.

- If you feel you need the assistance of an advocate other than a personal connection, you may wish to contact a be an advocate group, such as:
    - Human Rights Committee Chairperson; C/O Philadelphia OMH/MR Division of Mental Health Services; 1101 Market Street, 7th Floor; Philadelphia, PA 19107
    - National Alliance for Mentally Ill (NAMI); 2149 North 2nd Street; Harrisburg, PA 17110-1005
    - Pennsylvania Mental Health Patient's Association (PMHCA); 4105 Derry Street Harrisburg, PA 17111
    - U.S. Department of Justice Civil Rights Division; 950 Pennsylvania Avenue, NW; Disability Rights Section; Washington, DC 20530
    - HopeWorx, Inc.; 1210 Stanbridge Street, Suite 600; Norristown, PA 19401 (610) 270-3685

Client Name:	**Client DOB**:
I have read both pages of this form or they have been read to me. I have been given an opportunity to ask questions and those questions have been answered. My signature on this document indicates that I have been given a copy of the Client Rights Form, including a list of advocacy organizations, and that I understand the contents of this document.	
Signature of Client (if 14 years of age or older, and if capable of meaningfully signing):	**Date**:
Parent/Guardian signature: Relationship to Client:	**Date**:
Neurodiversity Consultants LLC Signature:	**Date**: