



Thank you for applying to the Sewall Diagnostic & Evaluation Clinic!

Evaluations are conducted in person at Sewall Child Development Center,
940 Fillmore Street, Denver, CO 80206.

Sewall is in the Congress Park neighborhood,
next to Congress Park in Central Denver,
and near the Denver Botanic Gardens.

We follow all CDC guidelines for COVID-19 restrictions
for child care centers.

Please return your completed application to **Rachel Sarconi**, Clinic Coordinator,
via one of the methods below:

- Scan and email to DEClinic@sewallchild.org. *Emailed applications must be scanned and sent as one PDF. We cannot accept individual photos or JPGs.*
- Fax to 303-327-5756
- Contact:
Rachel Sarconi
303.399.1800 x.143

Sewall Diagnostic & Evaluation Clinic Application

Please address every question. If a question does not apply, write N/A.

Today's Date: _____

Child's Name _____ Date of Birth _____

Age of Child _____ Gender _____

Caretaker(s) Name(s) _____

Relationship to Child _____

Address _____ Phone _____

City/State/Zip Code _____

Caretaker Email _____

Who has legal custody of referred child? _____

Please list everyone living in the child's current home and indicate relationship to child – biological parents and siblings; foster family's biological, foster, or adopted children:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Child's Medicaid ID: _____ Other funding source: _____

Who referred you and your child to our Clinic? _____

Please check any and all reasons your child is being referred by PCP, therapist, or other professional for evaluation:

- | | |
|--|--|
| <input type="checkbox"/> Possible Autism Spectrum Disorder | <input type="checkbox"/> Possible Anxiety Disorder |
| <input type="checkbox"/> Possible ADHD | <input type="checkbox"/> Global Developmental Delays |
| <input type="checkbox"/> Other Possible Diagnosis _____ | |

What concerns do you have about your child?

- | | |
|--|---|
| <input type="checkbox"/> Aggressive behavior | <input type="checkbox"/> Speech-language delays |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Fine motor delays |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Gross motor delays |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Sensory processing |

Sewall Child Development Center
Phone Number 303-399-1800 x.143

940 Fillmore Street, Denver, CO 80206
Fax Number 303-327-5756

Peer relationships/friendships Social skills

Please provide examples:

Is your child involved with child protective services? _____

Name of human services agency _____

Caseworker name _____

Phone _____ Fax _____

Caseworker email _____

Primary language of child _____

Primary language of parent/guardian _____

Can the child be tested in English? _____

Would a Spanish interpreter for parent be helpful? _____

Medical Information

Does your child have any medical diagnoses? (circle) YES NO If yes, please list:

Child's primary care provider (PCP) _____

Name of practice or clinic: _____

Address _____

Phone _____ Fax _____

Child's birth hospital _____

Address _____

Phone _____ Fax _____

Birth History

Pregnancy length: _____ Mother's age at birth: _____

Baby's birth length: _____ Birth weight: _____

Vaginal birth or Cesarean section: _____

Describe any complications with birth:

Describe any problems in the newborn period:

Were the following used during the pregnancy?

Tobacco – quantity _____

Alcohol – quantity _____

Prescription drugs – please list and explain:

Non-prescription drugs – please list and explain:

Medical History

Please list other medical professionals who have been and/or are also involved with your child:

Please list child's current medications:

Child's allergies:

Sewall Child Development Center
Phone Number 303-399-1800 x.143

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Has your child been seen at the Child Development Unit (CDU) at Children's Hospital Colorado, JFK Partners, or another agency for a comprehensive developmental evaluation?

If yes, when? _____

If yes, why? _____

Is there anything else you would like for us to know about your child?

Family History

Check if any of the child's relatives have had:

Yes

Relationship to Child

Drug abuse _____

Alcohol abuse _____

Police involvement _____

Speech-language delays _____

Hearing loss _____

Motor concerns _____

Learning disability _____

Intellectual disability _____

Mental illness _____

Autism Spectrum Disorder _____

School Information

Which school does your child attend? _____

School district _____ Grade _____

Phone number _____

Does your child have an Individual Education Plan (IEP)? _____

Does your child have an Individual Family Service Plan (IFSP)? _____

Therapist and Service Provider History

Sensorimotor

Has your child ever received physical and/or occupational therapy? _____

When and where? _____

Therapist's name and contact information:

Has your child ever received a motor evaluation? _____

When and where? _____

Was this evaluation provided by the school or a private therapist? _____

Speech and Language

Has your child ever received speech/language therapy? _____

When and where? _____

Therapist's name and contact information:

Has your child ever received a speech/language evaluation? _____

When and where? _____

Was this evaluation provided by the school or a private therapist? _____

Mental Health

Is your child under the care of a psychiatrist? _____

When did psychiatric care begin? _____

How often does s/he see the psychiatrist? _____

Psychiatrist contact information _____

Does your child work with a mental health therapist? _____

When did therapeutic care begin? _____

If yes, how often does s/he see his/her therapist? _____

Therapist contact information _____

Sewall Child Development Center
Phone Number 303-399-1800 x.143

940 Fillmore Street, Denver, CO 80206
Fax Number 303-327-5756

Has your child ever received either a

- Psychological evaluation
- Neuropsychological evaluation

Date of evaluation _____

Provider's name and contact information:

Funding Information

We gather Race and Ethnicity data in order to apply for funding. *Please select one for each category.*

Child's Race:

- Native American Indian Black or African-American
- Native Hawaiian/Pacific Islander
- Asian White Multiracial

Child's Ethnicity:

- Hispanic/Latino Non-Hispanic/Latino
- Prefer not to specify

Signature

Relationship

Date

Signature

Relationship

Date

Sewall Child Development Center
Phone Number 303-399-1800 x.143

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AUTHORIZATION TO DISCLOSE CONFIDENTIAL/HEALTH INFORMATION

1.) I authorize the Diagnostic & Evaluation Clinic at Sewall Child Developmental Center to obtain from and/or share health information regarding the individual named below:

Child's Name: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code _____

Phone Number: _____

2.) I authorize health information to be obtained from, and/or released to, the following individual or organization:

Sewall Child Development Center D&E Clinic

Phone Number: 303-399-1800 x.143 Fax Number: 303-327-5756

For the purpose of: Diagnostic Evaluation

3.) The type of medical information to be disclosed is as follows (check applicable):

_____ any/all birth records

_____ any/all medical records

_____ any/all therapy records

_____ any/all mental health records

_____ any/all initial and/or triennial IFSP/IEP records including evaluations

_____ other

4.) I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse, and past medical history, including birth records.

5.) If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected.

6.) I understand I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that this authorization will expire either one year from the date of signing, or upon this date that I have specified: _____

Parent's Printed Name: _____

Signature of Parent: _____ Date: _____

Signature of Legal Guardian: _____ Date: _____

Agency: _____

Please fax information to the Clinic Coordinator, Rachel Sarconi: 303-327-5756.

Placement History (if applicable)

Name of foster parents: _____ Phone Number: _____

Date removed from biological home: _____

Estimated duration of current placement: _____

Circumstances regarding removal: _____

In crisis center or receiving home from _____ to _____

If foster-to-adopt home, estimated finalized adoption date: _____

Please list all other placements prior to current home:

DATES

HOME – please state whether foster or biological relative (e.g., paternal grandparent, maternal aunt, etc.) and location

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Plan for child's permanent placement: _____

Sewall Child Development Center
Phone Number 303-399-1800 x.143

940 Fillmore Street, Denver, CO 80206
Fax Number 303-327-5756

PERMISSION TO TEST

Sewall Child Development Center
Diagnostic & Evaluation Clinic

Date: _____

I, _____, give permission for the Sewall Diagnostic & Evaluation Clinic team to administer standardized testing tools to my child, _____, in order to perform a full developmental evaluation, including cognitive, social-emotional, speech-language, and motor skills testing. I understand that this assessment will facilitate a program plan for my child and family. I also understand and agree that a copy of the report based on this evaluation will be sent to my child's primary care provider.

Signature of Parent

Signature of Legal Guardian

Agency: _____

Notice of Privacy Practices

**Sewall Child Development Center, Inc.
940 Fillmore Street Denver, CO 80206**

Effective 4/26/2019

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Please address any questions about this notice to Heidi Heissenbuttel, President/CEO, at 303-399-1800.

A record of care is maintained for all clients of Sewall Child Development Center. Typically, this record contains information regarding date and time of contact, behavioral/emotional symptoms, a client's reported thoughts and feelings, diagnostic information, information about treatment, and billing-related information. Information about a client's family members may also be contained in the record, as such information pertains to client treatment. This notice applies to all of the medical records of your child's care maintained by Sewall Child Development Center.

Sewall's Responsibilities

Sewall is required by law to maintain the privacy of your child's health information and provide you a description of its privacy practices. Sewall will abide by the terms of this notice and notify you if we cannot agree to a requested restriction. Sewall will accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

Uses and Disclosures

The following categories describe examples of the way Sewall may use and disclose medical information:

For Treatment: Sewall may use medical/mental health information about your child in the provision of services. When working with minor children who are under 15 years of age, Sewall may disclose medical/mental health information about the child to parents, caseworkers (if applicable), or those for whom consent has been provided to share information. Such sharing of information will be to coordinate care and promote the well-being of the minor child.

Sewall may provide other mental health providers, Department of Human Services representatives, legal representatives, and/or other medical professionals and family members with information that should assist them in their work with your child. Please understand that such releases of information occur only with informed consent and would be in case of medical/mental health emergency, the commission of criminal behavior on the part of the client, or by court order.

For Payment: Sewall operates through a fee-for-service arrangement in which it is required that clients reimburse Sewall directly. If services are being billed through Medicaid, an insurance provider, or other third party, Sewall will provide the requested information to the appropriate provider. In cases where Sewall provides information to an insurance carrier due to client request, Sewall may use and disclose medical/mental health information about your child's treatment and services. This may include information about symptoms, diagnostic information, information about the goals of treatment, and the treatment plan.

Sewall Child Development Center
Phone Number 303-399-1800 x.143

940 Fillmore Street, Denver, CO 80206
Fax Number 303-327-5756

For Health Care Operations: Sewall staff may use information in your child's health record to assess the care and outcomes in the case and others like it. The results will then be used to continually improve the quality of care for all clients we serve. For example, we may combine information about many clients to evaluate the need for new services or treatment. We may disclose information to outside entities for educational purposes. The disclosure of such information will not identify any clients. We may combine medical/mental health information we have with that of other treatment providers to allow us to see where we can make improvements. We may remove information that identifies your child from this set of medical information to protect your privacy.

We may also use and disclose medical/mental health information:

- To business associates we have contracted with to perform the agreed-upon service and billing for it
- To assess your satisfaction with our services
- To tell you about possible treatment alternatives
- As part of fundraising efforts
- For population-based activities relating to improving program outcomes or reducing treatment cost
- For conducting training programs or reviewing competence of mental health care for professionals

Business Associates: There are some services provided in our organization through contracts with business associates; with, for example, our accrediting body, which serves to support Sewall in maintaining high standards of care. When Sewall works with its accrediting body, we may disclose your child's health information to our business associates so that they can perform the job we've asked them to do. To protect your child's health information, however, we require the business associates to appropriately safeguard your information.

Individuals Involved in Your Care or Payment for Your Care: We may release medical/mental health information about your child to a parent, county caseworker, guardian ad litem, and/or probation officer who is involved in his/her treatment. In addition, we may disclose medical information about your child to an entity assisting in an emergency situation so that your family can be notified about your child's condition, status, and location. Such disclosure, except in cases of emergency, court order, or where existing laws mandate disclosure, are only done with appropriate consent.

Research: We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your child's health information has approved said research.

Organized Health Care Arrangement: This practice is presenting you this document as a notice. Information will be shared as necessary to carry out treatment, payment, and health care operations. Physicians and caregivers may have access to protected health information in their offices to assist in reviewing past treatment, as it may affect treatment at the time.

Affiliated Covered Entity: Caregivers at other facilities or practices may have access to protected health information at their locations to assist in reviewing past treatment information, as it may affect treatment at this time. Please contact Sewall's Clinic Coordinator at 303-399-1800 for further information on the specific sites included in this affiliated, covered entity.

As required by law, we may also use and disclose health information for the following types of entities, including but not limited to:

- The Food and Drug Administration
- Public health or legal authorities charged with preventing or controlling disease, injury, or disability
- Law-enforcement officials
- State and county departments of human services
- The courts
- Health oversight agencies

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

State-Specific Requirements: The Colorado Department of Human Services requires access to all records as part of its role in oversight of accredited diagnostic and evaluation clinics.

Your Health Information Rights

Because Sewall compiled your child's record which therefore is the physical property of Sewall, you have the right to:

- **Inspect and Copy:** You have the right to inspect and copy information that may be used to make decisions about your child's care. Usually, this means certain health and billing records but does not include therapy notes or other notes which we are legally forbidden to disclose. We may deny your request to inspect and copy in certain, very limited circumstances. If you are denied access to health information, you may request that the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Amend:** If you feel that the health/medical information we have about your child is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Sewall. We may deny your request for an amendment and, if this occurs, you will be notified of the reason for the denial.
- **An Accounting of Disclosures:** You have the right to request an accounting of the disclosures we make of medical information about your child.
- **Request Restrictions:** You have the right to request a restriction or limitation on the health/medical information we use or disclose about your child for treatment, payment, or health care operations. You also have the right to request a limit on the health/medical information we disclose about your child to someone who is involved in his/her care, or in the payment for his/her care, such as a family member or friend. For example, you could request that information shared about family members not be shared with those same family members.
- **We are not required to agree to your request:** If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
- **Request Confidential Communications:** You have the right to request that we communicate with you about health/medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you may ask that we not leave voice mail or email messages, or that notices of treatment staffing be mailed to an alternative location.
- **A Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To exercise any of your rights, please obtain the required forms from the Clinic Coordinator and submit your request in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and the revised or changed notice will be effective for information we already have about your child as well as any information we receive in the future. The current notice will be posted on Sewall's website (sewallchild.org) and include the effective date. In addition, each time you visit Sewall for treatment or health care services, we will have available a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Sewall by contacting Sewall's President/CEO at 303-399-1800. You may also file a complaint with the Colorado Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

Sewall Child Development Center
Phone Number 303-399-1800 x.143

940 Fillmore Street, Denver, CO 80206
Fax Number 303-327-5756

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to Sewall will be made only with your written permission. If you provide us permission to use or disclose medical information about your child, you may revoke that permission, in writing, at any time. If you revoked your permission, we will no longer use or disclose medical information about your child for the reasons covered by the written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to your child.

Heidi L. Heissenbuttel
President/CEO
Sewall Child Development Center
940 Fillmore Street
Denver, Colorado 80206
303-399-1800 (Main) or x.143 (D&E Clinic/Rachel Sarconi)

By my signature below, I acknowledge having received a copy of Sewall's "Notice of Privacy Practices." I may ask the Clinic team or Heidi Heissenbuttel, Sewall's President/CEO questions about this form. I may also request another copy of this Notice from Sewall's Clinic Coordinator, Rachel Sarconi.

Printed Name of Client _____

Printed Name of Parent _____

Signature _____ Date _____

Printed Name of Parent _____

Signature _____ Date _____

Printed Name of Legal Guardian (if other than biological or adoptive parent):

Agency _____

Signature _____ Date _____



SEWALL DIAGNOSTIC & EVALUATION CLINIC

Policies and Procedures: Your Rights as a Client

The following information describes Dr. Sharon S. Jacksi's clinical practice at Sewall Child Development Center's Diagnostic & Evaluation Clinic and provides a disclosure statement. Please review the following information carefully, and feel free to ask any questions that you may have.

Sharon S. Jacksi, Ph.D.

Licensed Clinical Psychologist
Sewall Child Development Center
940 Fillmore Street :: Denver, CO 80206 :: 303.399.1800
www.Sewall.org

SERVICES PROVIDED

I am a Colorado licensed psychologist (#769). Evaluation and consultation services are provided to children and their families at the Diagnostic & Evaluation Clinic at Sewall Child Development Center.

QUALIFICATIONS

Degrees: B.A. William Smith College
 M.A. Vanderbilt University–Peabody campus
 Ph.D. Vanderbilt University–Peabody campus

IMPORTANT INFORMATION

The practice of both licensed and unlicensed persons in the field of psychotherapy is regulated by the Colorado State Department of Regulatory Agencies. Any questions, concerns, or complaints regarding the practice of mental health may be directed to:

Mental Health Grievance Board
1560 Broadway, Suite #1350
Denver, CO 80202
303.894.7800

Regulatory requirements applicable to mental health professionals in Colorado include:

- **Registered psychotherapist** is a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy in Colorado but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.
- **Certified Addiction Counselor I (CAC I)** must be a high school graduate, complete required training hours and 1,000 hours of supervised experience.

Sewall Child Development Center
Phone Number 303-399-1800 x.143

940 Fillmore Street, Denver, CO 80206
Fax Number 303-327-5756

- **Certified Addiction Counselor II (CAC II)** must complete additional required training hours and 2,000 hours of supervised experience.
- **Certified Addiction Counselor III (CAC III)** must have a bachelors degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience.
- **Licensed Addiction Counselor** must have a clinical masters degree and meet the CAC III requirements.
- **Licensed Social Worker** must hold a masters degree in social work.
- **Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate** must hold the necessary licensing degree and be in the process of completing the required supervision for licensure.
- **Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor** must hold a masters degree in their profession and have two years of post-masters supervision.
- A **Licensed Psychologist** must hold a doctorate degree in psychology and have one year of post-doctoral supervision.

Your rights include the following:

1. You are entitled to receive information about the methods used during this evaluation process, the goals of this evaluation and information concerning fees. You will receive a copy of the written report that is produced from this evaluation. This report is typically sent 4 to 6 weeks following completion of the evaluation.
2. You may seek a second opinion regarding the outcome of this evaluation or terminate this evaluation at any time. In the case of a court ordered evaluation, second opinions and prematurely terminating an evaluation will likely need to be coordinated with the courts.
3. You should know that in a professional relationship sexual intimacy is never appropriate and should be reported to the Grievance Board.
4. Generally speaking, the information provided by and to the client during the evaluation is legally confidential and cannot be released without the client's consent. There are exceptions to confidentiality, some of which are listed in section 12-43-218 of the Colorado Revised Statutes, as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report suspected child abuse to authorities. If a legal exception arises during this evaluation, if feasible, you will be informed accordingly. The Mental Health Practice Act (CRS 12-43-101, et seq.) is available at: <http://www.dora.state.co.us/mental-health/Statute.pdf>.
5. Children diagnosed with reportable conditions, such as Autism and Fetal Alcohol Syndrome, are reported to the Colorado Department of Public Health, as required by State Statute.

DIAGNOSTIC & EVALUATION CLINIC

Sewall Child Development Center provides developmental evaluations for children ages infancy through mid-teen years. Children participating in the Clinic are evaluated by a multidisciplinary team of professionals that includes myself as the psychologist. In my role as psychologist, I will evaluate several areas of functioning that may include cognitive, academic achievement, adaptive behavior functioning and social-emotional domains. The evaluation process includes reviewing records of your child, obtaining information from caregivers, and obtaining information from your child. Information obtained from caregivers may include requests for caregivers to complete structured questionnaires, participate in structured interviews, and participate in less formal interviews. The purpose of this information gathering is to learn as much about your child as possible. Similarly, your child may be asked to complete more formal psychological tests, participate in interviews, and/or engage in play/activities with myself or other clinic staff. At times, a child's feedback may be audio-recorded for the purpose of accurate information gathering. Any recording is not shared, and it is erased upon completion of the evaluation. Again, the purpose of these activities is to learn as much about your child in a time-limited manner. The goal of the evaluation is to provide feedback on your child's functioning and to provide relevant recommendations that will support ongoing adaptive functioning. Unless court-ordered, your participation and your child's participation in this process is voluntary. The Clinic team is often available to provide verbal feedback immediately after the evaluation. This feedback will include initial impressions and some recommendations for follow-up. The Clinic team will also provide a written report that summarizes contact with your child, provides feedback on obtained results, and offers recommendations for ongoing follow-up. The completed report on your child may be released to those who have legal custody of your child. Besides parents, this may include the county human services agency in which you reside or whoever has custody of your child. If your child has a guardian ad litem, this representative of your child's

Sewall Child Development Center
Phone Number 303-399-1800 x.143

940 Fillmore Street, Denver, CO 80206
Fax Number 303-327-5756

interests may also obtain a copy of the report due to court orders stating that he/she has access to information about your child. It is the practice of Sewall's Clinic team to release a copy of the completed report about your child to your child's primary care provider (PCP). The purpose of sending a copy of the report to your child's PCP is to support continuity of care. The Authorization to Disclose Confidential Information form, which you signed prior to initiating this evaluation, indicates your approval for releasing the report to your child's PCP. If you do not wish to have the report released to your child's PCP, please share this with a clinic staff member as soon as possible. There may be other instances in which the final report about your child is released to other agencies, including the reporting of a reportable health condition and under court order.

FEES

The cost of a comprehensive evaluation is \$3,500.00. Fees are arranged between clients and Sewall prior to the evaluation taking place. A third-party payor, such as an insurance company, may cover the cost of services. If any costs will be assumed by the client and/or his/her parent/guardian, these will be fully explained to you. Please do not hesitate to ask any questions.

BILLING INFORMATION

If you are seeking coverage from an insurance company, Sewall's clinic coordinator will work with you to complete the necessary forms. Information about clients, including diagnostic information or other personal information, will be shared with your insurance company and associated managed care organization for the purposes of reimbursement.

If payment is guaranteed through another entity, such as an insurance carrier, it is understood that information may be shared with the insurance company in order to secure reimbursement. Your signature below indicates that personal information may be released to your insurance carrier.

CANCELLATIONS

Appointments are scheduled in advance. Sessions not cancelled within 24 hours of the appointment time may result in Sewall not being able to provide the Clinic evaluation in the future.

I have been informed of the license, degree, and credentials of Sharon S. Jacksi, PhD. I have read the preceding information, it has also been provided verbally, and I understand my rights as a client or as the client's responsible party.

Child's Name

Date of Birth

Parent or Legal Guardian **printed name**

Relationship to Child

Client, Parent or Legal Guardian **signature**

Date

Witness

Date