



Parent Consulting Registration Form

CHILD INFORMATION

Legal First Name: _____ MI: ___ Legal Last Name: _____

First Name Used: _____ Date of Birth: _____ Sex: Male Female Choose not to disclose

Street Address: _____ City: _____ State: _____ Zip: _____

Best Contact Phone Number: _____ Email: _____

Preferred Method of Contact (circle one): Phone Email Primary Language: _____

May we text you to confirm an appointment (circle one)? Yes No

How did you hear about us? *(Please share the name of the applicable individual/organization below.)*

Current Patient Physician Therapist School Website/Social Media Word of Mouth Other

Name of individual/organization who told you about the Cope Center for Autism: _____

FAMILY INFORMATION

Mother/Guardian Information:

First Name: _____ Last Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Best Contact Phone Number: _____ Email: _____

Preferred Method of Contact (circle one): Phone Email

Father/Guardian Information:

First Name: _____ Last Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Best Contact Phone Number: _____ Email: _____

Preferred Method of Contact (circle one): Phone Email

Parent or Guardian Signature: _____ Date: _____



Consent for Parent Consulting Services

1. CONSENT FOR SERVICES: I, _____ (parent name) (“Parent”) authorize the Cope Center for Autism, a NJ Non-Profit Corporation located at 579 Franklin Turnpike, Ridgewood, NJ 07450 (“Cope Center for Autism”) to provide parent consulting services as described in this Consent with respect to my child, _____ (child name) (the “Child”).

2. SERVICES: This Consent is for the purpose of providing parent consulting services to help Parent in making informed decisions concerning the support and educational needs of the Child. The Cope Center for Autism will use its best efforts to provide Parent with research-based information to advise and support Parent with respect to, as applicable, outside service providers and educational, therapeutic and/or transitional matters regarding the Child.

3. PARENT’S RESPONSIBILITIES: Parent agrees to (a) communicate fully with the Cope Center for Autism, providing all information that would aid the Cope Center for Autism in assisting Parent; and make payments to the Cope Center for Autism, as provided in this Consent.

4. CONFIDENTIALITY: Parent understands and acknowledges that the Cope Center for Autism agrees to keep all client information and records confidential.

5. FINANCIAL AGREEMENT: Parent understands and agrees that Parent is financially responsible for paying for any services received under this Consent in accordance with the regular rates and terms of the Cope Center for Autism.

Currently, services are billed at a rate of \$200 per hour, with time rounded to the nearest half hour. Parent understands that rates are subject to change within the discretion of the Cope Center for Autism.

Parent agrees to make prompt payment to the Cope Center for Autism for any and all charges due. The Cope Center for Autism will send Parent a statement for any and all time spent on the Child’s case, including time spent reviewing records, consultations with Parent, e-mail communication, and any and all other services requested or initiated by Parent. **No Shows and Cancellation Fees:** A \$50 fee applies to all parent consulting appointments cancelled less than 24 hours prior to the appointment time and no-shows to any scheduled appointments.

6. ELECTRONIC COMMUNICATIONS: Parent agrees that the Cope Center for Autism, or its designated vendor, may contact Parent by telephone, text message, email, mobile application, or US mail with

Child Name: _____

respect to the services herein, to request feedback on Parent's experience and/or to communicate with Parent regarding Parent's outstanding invoice(s). In the future, Parent may opt-out of receiving text messages by notifying the Cope Center for Autism in writing. This includes responding via text message. Standard telephone/text charges may apply if the Cope Center for Autism contacts Parent. Parent further agrees that, based on Parent's feedback, the Cope Center for Autism may utilize Parent's statements or comments, on an anonymous basis, on its website to provide reviews of its services that might help prospective clients choose its services.

7. DISCLAIMERS: The Cope Center for Autism will act on Parent's behalf in a courteous, conscientious, and careful manner. The Cope Center for Autism cannot promise or guarantee any specific outcome or result. This Consent does not bind Parent to solely use the Cope Center for Autism's parent consulting services. It is expressly understood by Parent that the services are not to be construed as advice or services in the fields of educational evaluation, psychology, financial services, law or medicine. **The Cope Center for Autism, cannot, in any circumstances, act as Parent's attorney.** Upon request, the Cope Center for Autism will provide Parent with names and phone numbers of special education attorneys or other service providers. In signing this Consent, Parent understands that there are no guarantees and holds the Cope Center for Autism and its affiliates harmless with regard to the services of unaffiliated providers, the outcome of financial government decisions and post-secondary outcomes.

8. LIABILITY: The Cope Center for Autism's and its affiliates' entire liability under this Consent, if any, for damages relating to this Consent and/or its performance pursuant to this Consent, whether based on contract or negligence, shall be limited to the amount paid to the Cope Center for Autism pursuant to this Consent relative to the period of occurrence of events which are the basis of such claims. In no event will the Cope Center for Autism be liable for any consequential damages arising from or in any way related to this Consent or the Cope Center for Autism's performance pursuant to this Consent.

9. TERMINATION OF CONSENT: Parent may terminate this Consent at any time, provided Parent has paid for all services delivered by the Cope Center for Autism. The Cope Center for Autism may terminate services under this Consent at any time in the event of nonpayment of fees or in the event irreconcilable differences develop.

10. SIGNATURE: By signing this Consent, Parent acknowledges that Parent has read and understands this Consent and that Parent agrees to all its provisions.

Parent Signature: _____

Date: _____

Parent Name: _____