Informed Consent for Evaluation and Treatment

As the authorized individual acting on behalf of your child, or as the undersigned patient (both referred to as the "Patient" below), please review this Evaluation and Treatment Consent Form carefully. Signing below indicates your voluntarily consent to the care of the Patient, encompassing outpatient evaluation and/or treatment under the care of Dr. Samantha Cohen, Developmental Behavioral Pediatrician and CEO of Samantha Cohen, MD, Inc.

1. **Nature and Purpose of Treatment**: I understand that the Patient will receive a developmental-behavioral evaluation and/or treatment which may include obtaining background information/history from caregivers and educators, a diagnostic assessment using standardized tests/evaluations and questionnaires, behavioral observations, clinical interviews, physical examination, counseling, individual and/or group therapy, medication consultation and ongoing medication management if a medication is prescribed, and if needed recommendations for further medical management/treatment through the Patient's primary care pediatrician/physician (i.e. recommendations for laboratory testing, general pediatrics/medical care, referral to other specialist, etc.).

2. **Potential Benefits**: Potential benefits of evaluation and treatment may include gaining a better understanding of the Patient's developmental and behavioral health, improved functioning, and enhanced well-being.

3. **Potential Risks**: I understand that all medical treatments carry potential risks and that no guarantees can be made about the outcome of the assessments or treatments. Risks may include, but are not limited to, unpleasant side effects of medication, allergic reactions, and/or possible discomfort during evaluations/examinations related to sensory sensitivities or when discussing challenges and/or diagnoses. Of note, these discussions are an important part of determining how to best provide support but can be uncomfortable and/or emotional for patient's and/or family members, so efforts are made to provide a safe, reassuring and trusting environment for these discussions.

4. **Alternatives to Treatment:** Alternatives to the proposed assessments and/or treatment plan will be discussed with the Patient as part of shared decision making with Dr. Cohen, and the Patient will have the opportunity to ask questions and consider other options. I also understand that the Patient has the right to choose to get care with a different provider if desired.

5. **Confidentiality**: I understand that all information disclosed as part of the Patient's care is confidential and may not be shared with anyone without my written permission, except in cases where disclosure is required by law (see Notice of Privacy Policies for details).

6. **Emergencies**: If there is an emergency while the Patient is under the care of Dr. Cohen, or in the future after care has ended, I understand that I and/or my child (if age appropriate) should call 911 right away and/or go to the nearest hospital emergency room right away.

7. **Right to Withdraw Consent**: I understand that I have the right to withdraw my consent for the assessment and/or treatment of the Patient at any time without affecting the Patient's right to future care or treatment.

By signing below, I acknowledge that I have read and understood all the information in this consent form, and that I agree to the evaluation and treatment of the Patient.

Patient Name: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____

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