



## Dyslexia & Processing Evaluation

### Parent/Guardian Agreement and Consent

Patient's Name: \_\_\_\_\_ Patient's Birth Date: \_\_\_\_\_

**OVERVIEW.** The *Dyslexia & Processing Evaluation* ("DPE") consists of three phases: **1.)** an approximately 90-minute, in-person evaluation of the above-named Patient with one (1) attending parent or guardian ("Parent/Guardian"—the person who is signing this Consent Form) present (please note that ***only the Patient and Parent/Guardian are permitted in the DPE session***); **2.)** a review of the results of the evaluation by the appointed staff of ACHIEVE, including at least one (1) doctor, and creation of a report that includes those results and ACHIEVE's recommendations (typically about a one-week process); and **3.)** the *Doctor Report and Review* ("DRR") meeting, which the below-signed Parent/Guardian agrees to attend ***without the Patient present***, during which meeting a doctor will review the report with the Parent/Guardian and share ACHIEVE's recommendations. At the Parent/Guardian's discretion, one (1) additional adult may attend the DRR with the Parent/Guardian. No other individuals are permitted in the DRR. The Parent/Guardian agrees to attend the DPE and DRR without any distractions (e.g., mobile devices, pets, etc.) present.

**CONSENT.** I, the undersigned Parent/Guardian of the above-named Patient, give permission to ACHIEVE's staff to administer a *Dyslexia & Processing Evaluation* to the above-named Patient, who will participate in the 90-minute evaluation phase of the process. Accommodations may be made to the evaluation as the doctor(s) and/or evaluation aide see fit (e.g., removing or simplifying a section due to Patient's short attention span, etc.).

**NATURE OF CONTENT.** I understand there may be sensitive questions asked of the Patient as part of the mental health section of the DPE. The questions are from the GAD-7 (General Anxiety Disorder) assessment and PHQ-9 (Patient Health Questionnaire). If I have any concerns about this section of the DPE, I may discuss them with the evaluation aide prior to beginning the evaluation.

**RECOMMENDATIONS AND LIABILITY.** The recommendations made by ACHIEVE are those of ACHIEVE's doctor(s). Referring parties accept no financial liability for payment of any services performed by providers recommended by ACHIEVE. Furthermore, ACHIEVE does not guarantee any specific result(s) from any recommended course(s) of action.

**FEE.** I understand that the complete cost for all three (3) phases of the DPE is four hundred fifty dollars (\$450) and that this fee is *not* covered by insurance. I agree to pay this fee on the day of the DPE session unless other prior arrangements have been made.

**ACKNOWLEDGEMENT AND COMMITMENT.** I understand that my attending the DPE session with the Patient and DRR (without the Patient) are integral and important parts of this evaluation. If I cannot attend either of these appointments as mutually scheduled, **I will call 801.492.6393 at least 24 hours before the scheduled meeting time to reschedule.** One (1) rescheduling of either the initial DPE session or DRR is allowed without incurring additional costs. If I miss either appointment without rescheduling at least twenty-four (24) hours in advance, or if I need to reschedule more than one (1) appointment, I agree to pay an additional one hundred twenty-five-dollar (\$125) appointment fee to set a new time for each affected appointment, which fee will be due at the time the rescheduled appointment is set. Rescheduled appointment times and fees are subject to the same missed appointment/rescheduling policy.

Parent/Guardian's Printed Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Parent/Guardian's Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_