Caregiver Consultation Services Agreement

Client/Caregiver: _____

Address: _____

Phone: _____

Email: _____

PURPOSE OF SERVICES

The Consultant provides caregiver education, coaching, consultation, and recommendations designed to support a child's participation, development, and success within natural environments and daily routines.

The Client is seeking consultation services to address concerns related to:

- ☐ Sensory Processing
- ☐ Emotional Regulation
- ☐ Daily Living Skills
- ☐ Executive Functioning
- ☐ Social Skills
- ☐ Play Skills
- ☐ School Participation
- ☐ Routines and Transitions

☐ Other: _____

NATURE OF SERVICES

The Client understands and agrees that:

- Consultation services are educational and coaching-based in nature.
- Services are intended to support caregivers through education, problem-solving, and individualized recommendations.
- The Consultant is not providing direct occupational therapy treatment under this Agreement.
- The Consultant is not establishing a therapist-client relationship with the child.
- Consultation services do not constitute medical diagnosis, treatment, or healthcare services.

- Recommendations are intended to support caregivers in implementing strategies within daily routines and environments.

The Client remains solely responsible for decisions regarding their child's medical, educational, therapeutic, and developmental care.

SERVICES PROVIDED

Services may include:

- Initial caregiver consultation
- Follow-up coaching sessions
- Review of caregiver concerns and goals
- Developmental and participation-based recommendations
- Home routine consultation
- Environmental modification recommendations
- Sensory and regulation consultation
- Resource recommendations
- Collaboration with other providers
- Written summaries and action plans
- Virtual or in-person consultation sessions

CONFIDENTIALITY

Hooked on Possibilities LLC will maintain the confidentiality of information shared by the Client to the extent permitted by law. Information may be disclosed when required by law, including but not limited to:

- Suspected abuse or neglect
- Threats of harm to self or others
- Court orders or legal requirements

The Client understands that email and electronic communication may not be completely secure.

LIMITATION OF SERVICES

The Client understands that consultation services:

- Are not medical care.
- Are not psychological counseling.
- Are not crisis intervention services.
- Do not replace evaluation or treatment by licensed healthcare providers.

The Consultant makes no guarantees regarding outcomes or progress.

Results vary based on numerous factors, including consistency of implementation, child characteristics, family circumstances, and environmental factors.

EMERGENCIES

The Consultant does not provide emergency services.

If the Client believes their child or another individual is experiencing a medical or mental health emergency, the Client should immediately contact:

- 911
- Their physician
- Local emergency services
- Appropriate crisis resources

RELEASE OF LIABILITY

The Client understands that the recommendations provided are educational in nature.

The Client assumes responsibility for implementing recommendations and releases the Consultant from liability arising from the use or misuse of information provided through consultation services, except where prohibited by law.

FEES AND PAYMENT

Initial Screening

Fee: Free Length: 30 minutes

Initial Consultation

Fee: $_____ Length: _____ minutes

Follow-Up Consultation

Fee: $_____ Length: _____ minutes

Payment is due prior to the scheduled session unless otherwise agreed in writing.

Accepted payment methods:

☐ Zelle - Heather Lynne Hook or 847-501-1837

☐ Venmo - @HeatherLHook

CANCELLATION POLICY

The Client agrees to provide at least twenty-four (24) hours' notice for cancellation or rescheduling.

Cancellations with less than twenty-four (24) hours' notice may be subject to a cancellation fee of $25.

No-shows may be charged the full session fee.

CLIENT ACKNOWLEDGMENT

By signing below, the Client acknowledges that they have read, understood, and agree to the terms of this Agreement.

Name: _____

Signature: _____

Date: _____

OPTIONAL PHOTO/TESTIMONIAL CONSENT

I authorize Hooked on Possibilities Pediatric OT Consulting to use anonymous feedback or testimonials for educational and marketing purposes.

☐ Yes

☐ No

Signature: _____

Date: _____