

In Person Caregiver Workshop Consent Form

I, _____ (Name of Parent/Guardian) hereby consent to
participate in Boomerang Health's *In Person Caregiver Workshop*.

Please place a checkmark next to the statement(s) below that you are in agreement with:

- ☐ I am aware of that the group is being completed at Boomerang Health;
- ☐ I agree that I have received information about the nature of the group and the expected outcomes;
- ☐ I am aware that a health record was created for myself/my child and that all of my/his/her records are confidential;
- ☐ I have been informed about how to access Boomerang Health's privacy policy (on the website);
- ☐ I understand that Boomerang Health will not share any information about me/my child with outside parties (e.g., school, physician, community programs) without my written consent.

Name of Parent/Guardian: _____

Relationship to Child: _____

Today's Date: _____

After each group session, an invoice will be provided for the session that was attended. If a session is missed, we are not able to issue an invoice for that date. We can only issue invoices for services that have been rendered. Please initial to signify that you have read and understand this policy: _____

We may take photographs or videos as part of our group programming. These are typically used as during reflective exercises and will not be used outside of the group or shared with anyone else. Do you consent to Boomerang Health taking pictures/videos of you? ☐ Yes ☐ No