



## Professional Consultation Waiver of Medical Liability

Child's Name: \_\_\_\_\_

### Parent Information

Parent's Name(s): \_\_\_\_\_

Home Address: \_\_\_\_\_

Phone (home): \_\_\_\_\_ Phone (cell): \_\_\_\_\_

E-mail Address: \_\_\_\_\_

### School/Treating Professional Information

School/Organization Name: \_\_\_\_\_

School/Organization Address: \_\_\_\_\_

School/Organization Main Contact's Name: \_\_\_\_\_

School/Treating Professional's Title: \_\_\_\_\_

School/Treating Professional's Contact Phone Number: \_\_\_\_\_

School/Treating Professional's Contact Email: \_\_\_\_\_

Professional performing Professional Consultation: Dr. Shipon-Blum

### **By signing below, you understand and agree to the following:**

A Professional Consultation is for informational and educational purposes only and is not meant to replace an initial in-person evaluation of your child/student.

Information presented to you during the Professional Consultation is based solely on what you state during your consult, is general information, and is not meant to be specific to your child/student.

At no time is a medical or psychological diagnosis made or confirmed.

There is no submission of pertinent records nor a child evaluation done for a Professional Consultation.

Therefore, in no event shall the SMART Center or professional representatives of SMART Center be

liable to you or anyone else for any decision made or action taken by you in reliance on this information.

There is no clinician-patient relationship developed from a Professional Consultation.

Parent Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_

School Representative's Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_