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## Non-Discrimination Policy

This practice is committed to providing services in a safe, respectful, and inclusive environment for all individuals.

In accordance with applicable federal and state laws, Pediatric Neuropsychology Associates PLLC does not discriminate on the basis of:

- Race
- Color
- National origin
- Sex (including pregnancy and related conditions)
- Gender identity or expression
- Sexual orientation
- Religion
- Age
- Disability
- Language
- Genetic information
- Marital status
- Military or veteran status
- Any other characteristic protected by law

All clients have the right to receive services free from discrimination, harassment, or retaliation. Reasonable accommodations will be provided when required by law and clinically appropriate to support access to services.

**If you believe you have been discriminated against or denied accommodations, you may contact us directly:**

Pediatric Neuropsychology Associates PLLC  
2699 Stirling Rd Suite C306C, Ft. Lauderdale, FL 33312  
954-284-0048

You also have the right to file a complaint with the Office for Civil Rights at the U.S. Department of Health and Human Services:

Phone: 1-800-368-1019  
Website: <https://www.hhs.gov/ocr>  
Email: [OCRComplaint@hhs.gov](mailto:OCRComplaint@hhs.gov)

## Electronic Signatures and Records

By signing this form electronically, I agree that my electronic signature and any related electronic records shall have the same legal validity and enforceability as a handwritten signature and paper documents. I acknowledge the use of electronic records for this agreement.

## Parent or Legal Representative Acknowledgment of Receipt and Review (for Minors or Individuals Lacking Legal Capacity)

I acknowledge that I have read and understand the Non-Discrimination Policy of Pediatric Neuropsychology Associates PLLC. I understand that this document is provided for informational purposes and does not require my consent for services.

By signing below, I confirm that I am the parent or legal representative of the patient named below and that I have the legal authority to receive and acknowledge this information on the patient's behalf.

I understand that I am not required to sign this acknowledgment. If I choose not to sign, the practice will document that the document was provided to me.

Printed Name of Patient:

Printed Name of Parent/Legal Representative:

Signature of Parent/Legal Representative:

Relationship to Patient:

Date:

*A copy of this signed form will be retained in the patient's health records.*

## For Office Use Only

Date Received:

Received By:

Staff Role:

Filing Method: ☐ Paper File ☐ Digital File ☐ Both

Notes: