

# CONSENT TO TREAT MINOR

Child's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Sex: \_\_\_\_\_

Age: \_\_\_\_\_ D.O.B.: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Child's primary address: \_\_\_\_\_

If none, please provide alternate address: \_\_\_\_\_

Please list any medications prescribed for minor: \_\_\_\_\_

Doctor: \_\_\_\_\_ Last seen: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Psychiatrist: \_\_\_\_\_ Last Seen: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

List any head injuries, past or present major illnesses or allergies: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ IEP or Special Ed? Y / N GPA: \_\_\_\_\_

Father's Name: \_\_\_\_\_ D.O.B.: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Mother's Name: \_\_\_\_\_ D.O.B.: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Guardian's Name: \_\_\_\_\_ D.O.B.: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

### *In Case of Emergency Contact:*

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

### *Please check all boxes that apply to minor and family:*

\_\_\_\_\_ Divorce \_\_\_\_\_ Legal Separation \_\_\_\_\_ Custody \_\_\_\_\_ Guardianship

\_\_\_\_\_ Restraining Orders \_\_\_\_\_ Current Litigation Issues \_\_\_\_\_ Probation

*Any issues concerning Divorce, Custody, Guardianship, Restraining Orders and/or Probation will require all documents to be presented on first visit to verify any legal issues and/or custody of child. Copies of these documents will be kept with minor's records.*

I, (print name) \_\_\_\_\_, am the (circle one) mother/father/legal guardian of \_\_\_\_\_, and I authorize Mindful Therapy Center, to provide psychotherapy to said minor. I also agree to be legally responsible for any charges said minor might incur during therapy with Mindful Therapy Center.

\_\_\_\_\_ (Initial)

Signature: \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Witness Signature: \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_