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Consent Form for Treatment of Minors with Divorced or Separated Parents

M+M Wellness Center, Inc will not initiate/continue pharmacological treatment of a minor until we have been provided this signed document in its entirety. Any parents or legal guardians who are listed in the court decree, as having medical and/or psychiatric decision-making authority must sign this treatment consent form prior to initiating/continuing a treatment plan. M+M Wellness Center, Inc is not liable in the event either guardian does not provide truthful information pertaining to or abide by the court decree they have been granted.

Please initial next to each statement to indicate your understanding and agreement:

 , It is not the responsibility of M+M Wellness Center, Inc to ensure that parents and legal guardians adhere to the terms of a legally binding divorce decree.

 , We expect divorced parents to communicate with each other about services rendered and to determine who will schedule appointments, who will bring the child to treatment, who will administer medication, be responsible for appointment fees etc. The clinician and the child will not be messengers between parents.

 , Consent for the minor patient's treatment must be given by both parties before/during the scheduled appointment, either by both parties signing this document and providing it to the clinician, by being present at the appointment w/ completed signatures, or by one party being present by telephone during the appointment w/ completed signatures. Your clinician cannot take time from your child's care by contacting you to obtain consent before or after the appointment. Violation of this policy will result in termination of care.

 , Failure of one or more of a minor patient's medical decision makers to agree to the recommended treatment plan will result in the minor patient being discharged from the clinic.

 , Your initials indicate that you will not request or require your clinician or others affiliated members with M+M Wellness Center, Inc, through subpoena, summons, or other means, to provide testimony in any legal proceeding relating to the care and custody

of your child. We will not testify in court about custody issues as it is not our role to conduct custody evaluations or determine whether a parent is "fit" to fulfill parental duties.

STATEMENT OF LEGAL GUARDIAN (PRIMARY)

I _____ (legal guardian) give my permission to _____ (other legal guardian) and my child's clinician(s) at M+M Wellness Center, Inc to make decisions regarding pharmacologic and therapeutic interventions, scheduling appointments, and cancelling appointments, if I am not physically present during any appointments.

I accept the responsibility of communicating with _____ (other legal guardian) after every appointment regarding any change in the treatment plan. I understand that my child's clinician will not contact me outside of my child's scheduled appointment time to obtain consent for these changes, however I may contact the clinician if I wish to withdraw consent to a change in treatment regimen.

I understand that failure for myself and my child's other legal guardian to agree to the recommended treatment plan will result in my child being discharged from the clinic.

I understand that if the above policies are violated or I choose not to adhere to these policies, my child will be discharged from this clinic.

Patient Name: _____ Date: ____/____/____

Legal Guardian #1 Name: _____ Signature: _____

STATEMENT OF LEGAL GUARDIAN (SECONDARY)

I _____ (legal guardian) give my permission to _____ (other legal guardian) and my child's clinician(s) at M+M Wellness Center, Inc to make decisions regarding pharmacologic and therapeutic interventions, scheduling appointments, and cancelling appointments, if I am not physically present during any appointments.

I accept the responsibility of communicating with _____ (other legal guardian) after every appointment regarding any change in the treatment plan. I understand that my child's clinician will not contact me outside of my child's scheduled appointment time to obtain consent for these changes, however I may contact the clinician if I wish to withdraw consent to a change in treatment regimen.

I understand that failure for myself and my child's other legal guardian to agree to the recommended treatment plan will result in my child being discharged from the clinic.

I understand that if the above policies are violated or I choose not to adhere to these policies, my child will be discharged from this clinic.

Patient Name: _____ Date: ____/____/____

Legal Guardian #2 Name: _____ Signature: _____