BENJAMIN'S
BEHAVIORAL HEALTH

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Consent Form for Treatment of Minors with Divorced or Separated Parents

Benjamin's Behavioral Health Services will not initiate treatment for minors of divorced or separated parents until we have been provided with a copy of a legal divorce decree or custody agreement. Any parent or legal guardians who are listed in the decree as having medical and/or psychiatric decision-making authority must sign this treatment consent form prior to initiating a treatment plan.

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

_____ _____It is not the responsibility of Benjamin's Behavioral Health Services or any of its affiliates to ensure that parents or legal guardians adhere to the terms of a legally bending divorce decree

_____ _____We expect divorced or separated 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, etc. The clinician and the child will not be messengers between parents.

_____ _____Consent for the minor patient's treatment must be given by both parents during the scheduled appointment, either by both parents being present or by missing parent being present by telephone during the appointment. Your clinician cannot take the time from your child's care by contacting you to obtain consent before, during 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 being discharged from the clinic.

_____ _____Your initials indicate that you will not request or require your clinician or other affiliates of Benjamin's Behavioral Health Services, 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.

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Consent Form for Treatment of Minors with Divorced or Separated Parents (Cont'd)

Statement of Legal Guardian (Primary)

I, _____(legal guardian) give permission to _____(other legal guardian) and my child's clinician(s) at Benjamin's Behavioral Health Services to make decisions regarding medical treatment, scheduling appointments, and cancelling appointments, if I am not physically present during any appointments.

I accept the responsibility of communicating with _____after every appointment regarding any changes in the treatment plan. I understand that my child's clinician will not contact me outside of my child's scheduled appointment to obtain consent to 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 the clinic.

Patient Name: _____ Date of Birth: _____

Signature: *_____ Date: _____

Legal Guardian (Primary) Name: _____

Statement of Legal Guardian (Secondary)

I, _____(legal guardian) give permission to _____(other legal guardian) and my child's clinician(s) at Benjamin's Behavioral Health Services to make decisions regarding medical treatment, scheduling appointments, and cancelling appointments, if I am not physically present during any appointments.

I accept the responsibility of communicating with _____after every appointment regarding any changes in the treatment plan. I understand that my child's clinician will not contact me outside of my child's scheduled appointment to obtain consent to 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 the clinic.

Patient Name: _____ Date of Birth: _____

Signature: *_____ Date: _____

Legal Guardian (Primary) Name: _____