Whole Life Psychiatry

Kim D. Tubbs, PMHNP, PA, Inc.

CONSENT FOR TREATMENT FOR MINOR CHILD

You have the right, as a parent or guardian, to be informed about your child's condition and the recommended medical or diagnostic procedures to be used so that you may make the decision whether or not to undergo any suggested treatment. This consent form is to obtain your permission to perform the evaluation necessary to identify appropriate treatment.

You have the right to discuss the treatment plan with your provider regarding the purpose, potential risks, and benefits of any treatment recommended by your provider.

Child/Adolescent Patients and/or Patients with Legal Guardians

With whom (both parents, one parent, other) does the child/adolescent reside?

_____

Who has legal custody of the child/adolescent? _____

Person(s) authorized to accompany child/adolescent to appointments and make treatment decisions:

_____

I/We accept the conditions for receiving services from Kim Tubbs, PMHNP and consent to treatment for

_____
Printed name of patient

_____

_____
Printed name of parent(s) or guardian(s)

_____

_____
Signature of parent(s) or guardian(s)

Date: ___/___/___