# CONSENT FORM FOR TREATMENT OF MINORS WITH DIVORCED OR SEPARATED PARENTS

Specialty Clinic of Austin will not initiate treatment for minors of divorced parents until we have been provided with a copy of a legal divorce decree or custody agreement. **Any parents 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 Specialty Clinic of Austin or any of its affiliates 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, 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 during the scheduled appointment, either by both parties being present at the appointment or by one party being present by telephone during the appointment. 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 with Specialty Clinic of Austin, 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, determine whether a parent is "fit" to fulfill parental duties,

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# CONSENT FORM FOR TREATMENT OF MINORS WITH DIVORCED PARENTS (Cont'd)

## STATEMENT OF LEGAL GUARDIAN (PRIMARY)

I _____ (legal guardian) give my permission to _____ (other legal guardian) and my child's clinician(s) at Specialty Clinic of Austin 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.

☐ I agree that my electronic signature on this application is binding and enforceable, as if I had signed a paper copy.

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 Specialty Clinic of Austin 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.

☐ I agree that my electronic signature on this application is binding and enforceable, as if I had signed a paper copy.

Patient Name: _____ Date: _____

Legal Guardian #2 Name: _____ Signature: _____

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