PREMIER PSYCHIATRY

PSYCHIATRIC AND BEHAVIORAL HEALTH SERVICES

10745 165th Street
Orland Park, IL 60467

P: 708-799-8384 F: 708-799-1305
www.premierpsychiatry.net

6833 Kingery Highway
Willowbrook, IL 60527

MINOR CONSENT TO TREATMENT FORM

1. MINOR PATIENT INFORMATION

Full Name: _____

Date of Birth: _____

2. PARENT / LEGAL GUARDIAN INFORMATION

Name: _____

Relationship to Minor: _____

Phone: _____

Email: _____

Address: _____

3. LEGAL AUTHORITY TO CONSENT

☐ **I confirm that I am the legal parent or court-appointed guardian of the above-named minor.**

☐ **I have full legal authority to consent to medical and psychiatric treatment.**

4. CUSTODY STATUS (REQUIRED)

☐ Married / Living Together

☐ Divorced / Separated

☐ Joint Legal Custody

☐ Sole Legal Custody (documentation may be requested)

☐ Other: _____

I agree to provide custody documentation upon request.

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5. CONSENT TO TREATMENT

I consent to psychiatric evaluation and treatment for the above-named minor at Premier Psychiatry.

I understand that treatment may include:

- **Diagnostic evaluation**
- **Medication management (including psychotropic medications)**
- **Ongoing psychiatric care**

I acknowledge that:

- **The provider will discuss risks, benefits, and alternatives during visits**
- **Treatment decisions will be made collaboratively**

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6. MEDICATION CONSENT

I understand that if medication is recommended:

- **Potential benefits and risks will be explained**
- **Side effects may occur**
- **Monitoring may be required**

I agree to:

- **Follow treatment recommendations**
- **Report side effects promptly**
- **Discuss any concerns with the provider**

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7. COMMUNICATION & INFORMATION SHARING

Please indicate who is authorized to receive information about the minor:

☐ Both parents/guardians

☐ Only the signing parent/guardian

☐ Other (specify): _____

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8. FINANCIAL RESPONSIBILITY

I accept financial responsibility for all services provided to the minor.

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9. ACKNOWLEDGMENT

I certify that:

- **The information provided is accurate**
- **I have the legal authority to consent**
- **I understand this consent will be reviewed during the clinical visit**

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10. SIGNATURE

Signature of Parent/Guardian: _____

Printed Name: _____

Date: _____
