Informed Consent for Ordinary Mental Health Treatment Provided to Minor

IMPORTANT: PLEASE READ CAREFULLY BEFORE SIGNING THIS FORM. THE MENTAL HEALTH SERVICES AND SUPPORTS THAT ARE AVAILABLE TO YOU MUST BE EXPLAINED PRIOR TO YOUR SIGNING.

I hereby consent to receive mental health services and supports form Whitman-Walker Health for the purpose of addressing mental health concerns/symptoms. Whitman-Walker Health has given me information about the purpose, side effects and potential risks and benefits, as well as feasible alternatives when applicable, to the identified mental health treatment.

Printed Name of Patient:	**Date of Birth:**
Signature: *(If applicable)*	**Date:**

Consent of parent or legal guardian (if applicable):

I have a right to accept or refuse mental health service and supports for the above listed minor patient, and hereby consent to the minor patient receiving mental health services and supports for the purpose of addressing mental health concerns/symptoms.	
Printed Name of Parent/Legal Guardian:	
Relationship to Patient:	
Signature:	**Date:**

Informed Consent to Treatment (Other Than Medication) by a Psychiatrist

Diagnoses:

AXIS I:	
AXIS II:	
AXIS III	

I hereby consent (for myself/for my child) (circle one) to receive treatment by a psychiatrist for the purpose of addressing mental health concerns/symptoms; AND

The following has been discussed with me by the mental health provider:

- The diagnosis and target symptoms.
- The possible benefits/intended outcome of treatment.
- The possible risks and side effects.
- The possible alternatives.
- The possible results of not accepting the treatment.
- I have been given the opportunity to ask questions about the treatment.

I also understand that I have the right to give informed consent or refuse to consent to specific mental health supports, services, and treatments that are offered or recommended.

I UNDERSTAND THAT THE INFORMATION PROVIDED TO ME AND MY SIGNATURE BELOW ACKNOWLEDGES THAT I CONSENT TO THE TREATMENT PROVIDED TO ME OR MY MINOR CHILD OR WARD BY A PSYCHIATRIST AT WHITMAN-WALKER HEALTH.

OR

_____ COURT ORDER PROVIDED (copy attached)
Initials of medical provider to verify that a copy is attached

Printed Name of Patient:	**Date of Birth:**
Signature: *(If applicable)*	**Date:**
Printed Name of Parent/Legal Guardian:	
Relationship to Patient:	
Signature:	**Date:**
Printed Name of Medical Practitioner and Credential:	
Signature:	**Date:**