Greatland Clinical Associates

1400 W. Benson Blvd., Ste. 315 Anchorage, AK 99503
(907) 929-4009 Fax (907) 929-4902

Consent To Treat Minor

CHILD'S NAME: _____ **DOB:** ___/___/___
Primary Address: _____
Home Phone: _____ **SS#:** _____-____-_____ **Age:** _____

PARENTS: *(Name all parents/step-parents/legal guardians. CUSTODIAL parent(s) must sign form)*

Mother: _____ **Spouse:** _____
Address: _____
SS#: _____-____-_____ **DOB:** ___/___/___ **Age:** ____ **Occupation:** _____
Cell Ph: _____ **Work Ph:** _____ **Home Ph:** _____

Father: _____ **Spouse:** _____
Address: _____
SS#: _____-____-_____ **DOB:** ___/___/___ **Age:** ____ **Occupation:** _____
Cell Ph: _____ **Work Ph:** _____ **Home Ph:** _____

Guardian: _____ **Spouse:** _____
Address: _____
SS#: _____-____-_____ **DOB:** ___/___/___ **Age:** ____ **Occupation:** _____
Cell Ph: _____ **Work Ph:** _____ **Home Ph:** _____

Emergency Contact:
Name: _____ **Relationship:** _____ **Phone:** _____
Name: _____ **Relationship:** _____ **Phone:** _____

As the legal guardian with the authority to consent on behalf of the minor child named above, I hereby give my consent for the minor child to obtain counseling/therapy, psychiatric assessment and treatment, and/or psychological testing and assessment from the professional staff of Greatland Clinical Associates. This consent will be valid until the minor reaches the age of 18, but can be revoked at any time by written notification of the guardian(s).

I agree and understand that while the insurance may be billed for psychiatric and mental health services, I am legally responsible for all of the charges incurred while providing these services by this clinic. Copies of the documentation of sole legal custody of child must be provided on or before the first date of service, otherwise; both parents must sign the consent for treatment form.

_____ _____
CUSTODIAL PARENT (Mother/Father/Guardian - Circle One) **DATE**

_____ _____
CUSTODIAL PARENT (Mother/Father/Guardian - Circle One) **DATE**