Unwritten Endings, LLC
10075 Bergin Rd. Suite C
Howell, MI 48843
P: (810) 444-2484
F: (810) 272-4991

Parent Authorization, Agreement, and Consent for Treatment of Child

As a mental health clinic, our responsibility and goal is the well-being of our identified clients. In the case of a child as the primary client, it is essential that parents and/or legal guardians are in an agreement as to the decision to treat, the treatment goals, appointment times and the need to maintain client confidentiality. As a result, it is the policy of our clinic (herein referred to as "The Clinic") that all minors presented for treatment have the following authorization and consent on file.

Please check the box that is most appropriate:

☐ **Both parents are living, have legal custody of the minor child, consent to treatment and have signed this document**

- Both legal parents/guardians agree to the treatment and providing of mental health services for their child and will indicate their consent below. If there is no custody agreement in place, the parent signing is indicating that both parents are fully aware of and in and support the mental health treatment that is being provided for the minor named below.
- If the biological or legally adopted parents are currently separated or going through the divorce process, both parents are still required to sign a Consent for Mental Health Treatment Form before the child can be treated.

☐ **One parent has legal custody of the minor child and both parents have signed this document**

- There is an official certified divorce decree or a legal custody order that indicates that only one parent is legally permitted to determine and decide on mental health treatment of the child without the consent of other parent (In this case, please provide us with a certified copy of this legal document in its entirety).

☐ **One parent is absent, missing, or deceased and only one parent has signed this document**

- The parent presenting child for treatment has no access to other parent due to the following reasons (death, incarceration, missing, has left and made no contact, etc.) and therefore will acknowledge that they are the sole primary caretaker of the child for mental health treatment and will bare all responsibility for such consent.

Minor Child: _____

Parent Signature: _____ Date:_____

Parent Signature: _____ Date:_____

Therapist Signature: _____ Date:_____

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Parent Authorization, Agreement, and Consent for Treatment of Child Continued

Both Legal Parents/Guardians Consent to Treatment

Legal Parent 1:

I, _____, _____ of _____,
(parent/legal guardian name) (relationship to child) (child)

hereby authorize, with the total understanding of the above-mentioned terms and conditions, my child to receive mental health treatment at Unwritten Endings, LLC and assume all financial responsibility for their treatment.

- I affirm that I have the authority to make health care decisions for my child and am aware that all custodial parents and legal guardians must give consent before treatment begins.
- I understand and agree that any breach of these agreements may result in the termination of any, and all, of my child's relationship with The Clinic or any of its providers, affiliates, and/or staff members. I have been given the opportunity to ask any questions I may have had and am voluntarily signing this agreement.

Name of Parent: _____

Signature: _____ Date: ____/_____/____

Legal Parent 2:

I, _____, _____ of _____,
(parent/legal guardian name) (relationship to child) (child)

hereby authorize, with the total understanding of the above-mentioned terms and conditions, my child to receive mental health treatment at Unwritten Endings, LLC and assume all financial responsibility for their treatment.

- I affirm that I have the authority to make health care decisions for my child and am aware that all custodial parents and legal guardians must give consent before treatment begins.
- I understand and agree that any breach of these agreements may result in the termination of any, and all, of my child's relationship with The Clinic or any of its providers, affiliates, and/or staff members. I have been given the opportunity to ask any questions I may have had and am voluntarily signing this agreement.

Name of Parent: _____

Signature: _____ Date: ____/_____/____

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Parent Authorization, Agreement, and Consent for Treatment of Child Continued

Legal Parent/ Non-Custodial Parent Consent to Treatment

Legal Parent:

I, _____, _____ of _____,
(parent/legal guardian name) (relationship to child) (child)

hereby authorize, with the total understanding of the above-mentioned terms and conditions, my child to receive mental health treatment at Unwritten Endings, LLC and assume all financial responsibility for their treatment.

- I affirm that I have the authority to make health care decisions for my child and am aware that all custodial parents and legal guardians must give consent before treatment begins.
- I understand and agree that any breach of these agreements may result in the termination of any, and all, of my child's relationship with The Clinic or any of its providers, affiliates, and/or staff members. I have been given the opportunity to ask any questions I may have had and am voluntarily signing this agreement.

Name of Parent: _____

Signature: _____ Date: ____/_____/____

Non-Custodial Parent:

I, _____, _____ of _____,
(non-custodial parent name) (relationship to child) (child)

hereby authorize, with the total understanding of the above-mentioned terms and conditions, my child to receive mental health treatment at Unwritten Endings, LLC

- I understand that this document does not provide me with legal custody of my minor child.
- I understand and agree that any breach of these agreements may result in the termination of any, and all, of my child's relationship with The Clinic or any of its providers, affiliates, and/or staff members. I have been given the opportunity to ask any questions I may have had and am voluntarily signing this agreement.

Name of Parent: _____

Signature: _____ Date: ____/_____/____

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Parent Authorization, Agreement, and Consent for Treatment of Child Continued
Absent, Missing, or Deceased Parent

I, _____, _____ of _____,
(parent/legal guardian name) (relationship to child) (child)

hereby acknowledge that with the total understanding of the above-mentioned conditions and terms of agreement, authorize my child to receive mental health treatment at Unwritten Endings, LLC and assume all financial responsibility for their treatment.

- I affirm that I have the authority to make health care decisions for my child and am aware that all custodial parents and legal guardians must give consent before treatment begins. I stipulate that a good faith effort was made to obtain the consent of the other parent, but this parent is either completely uninvolved in the child's life, the parent was not reachable/did not respond to efforts to reach him/her, and/or is not capable of informed consent.
- I understand that given circumstances in which the other parent is not reachable, completely uninvolved in the child's life (no contact at all with the child for at least several years), or incapable of informed consent), Unwritten Endings will provide treatment for my child without the consent of the child's other parent. However, I agree that if the child's parent should become available or involved in the child's life that this parent's consent will be required for treatment and that I will adhere to the policies regarding the Parent Authorization, Agreement, and Consent for Treatment of Child.
- I hereby swear and affirm under any applicable perjury laws that there is no legal divorce decree, custody order, or separation agreement that restricts or limits me from making any or all decisions in regard to my child's mental health treatment. I further acknowledge that Unwritten Endings, LLC has asked and attempted to collect any and all such documents from me.
- I further acknowledge and agree that it is ultimately my responsibility to make sure that I am following all legal conditions set forth by my divorce decree, separation agreements, etc. and acknowledge that Unwritten Endings, LLC is only requesting any and all related documents for the benefit of my child and therefore release any liability to Unwritten Endings, LLC, any of its providers, office staff, and/or affiliates resulting from a dispute to this authorization.
- I understand and agree that any breach of these agreements may result in the termination of any and all of my child's relationships with The Clinic or any of its providers, affiliates, and/or staff members. I have been given the opportunity to ask any questions I may have had and am voluntarily signing this agreement.

Name of Parent: _____

Signature: _____ Date: ____/_____/____