APN BEHAVIORAL HEALTHCARE
503 West Main St
Waxahachie, TX 75165
PH: (972) 937-5252 Fax: (972) 937-5259
apnbehavioralhealthcare@gmail.com

REGISTRATION FORM

(Please Print)

Today's date:	Provider:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name?		If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex:	
❑ Yes	❑ No			/ /		❑ M	❑ F

Street address:	Social Security no.:	Home phone no.:
		( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.:
		( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.		❑ Insurance Plan	❑ Hospital
❑ Family	❑ Friend	❑ Close to home/work	❑ Internet	❑ Other

Other family members seen here:	

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
	/ /		( )
Is this person a patient here?	❑ Yes ❑ No		

Occupation:	Employer:	Employer address:	Employer phone no.:
			( )

Is this patient covered by insurance?	❑ Yes	❑ No	

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:
		/ /			$

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize APN Behavioral Healthcare or insurance company to release any information required to process my claims.

	Patient/Guardian signature		*Date*

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ATTENTION PATIENTS:

Please be aware, appointment reminder emails and calls are a courtesy, NOT an obligation.

A late cancellation is defined as a cancellation less than 24 hours before the appointment.

No show & late cancellation fees will be charged to the client's credit card on file the day of the occurrence.

To avoid late cancellation/no show charges, please call at least 24 hours before the appointment time.

There is a 24-hour voicemail service available at all times which may be used to cancel appointments.

Insurance does not cover no show/late cancellation fees.

Outstanding balances on patients' accounts will be charged to the credit card on file.

FEES NOT COVERED BY INSURANCE:

- No Shows and Late Cancellations for Med Check: $120
- No Shows and Late Cancellations for New Patient Appt: $320
- No Shows and Late Cancellations for Therapy: $90
- Phone Appointments or Consultations: $120
- Records requested or copies needed first 20 pages: $25
- Forms/paperwork completed by the providers: Start at $25
- Prescription refill requests outside an appointment: $25
- Prior Authorizations: $25

FEES COVERED BY INSURANCE:

- **Appointments with Nurse Practitioner/Physician's Assistant:**
  - Med Check (15 minute): $120
  - Therapy (45 minutes): $240
  - New Patient: $320
- **Appointments with Licensed Professional Counselor:**
  - Therapy: (45-60 minutes) $90
  - New Patient: (45-60 minutes) $120

_____

Patient Name (Please Print)

_____ _____

Patient or Parent/Guardian Signature **Date**

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Credit Card Authorization Form

I, _____ (*Patient or Responsible Party – please print*), consent for treatment to be rendered to me, my dependent, or other person designated below, and, in so doing, agree to be responsible for the payment of professional fees. **I agree to provide a current debit/credit card, to be kept on file and understand that it will only be used to collect incurred fees. Fees may include, but are not limited to, no shows/late cancellations, patient copays, deductibles, non-insured services (i.e., prescription renewals outside your appointment time, pharmacy authorizations, telephone calls, document preparation, hospital admission coordination), or services deemed by my insurance company or its agents are medically unnecessary. In the event my insurance coverage cannot be verified prior to service delivery, I agree that I will be responsible for payment in full. I further agree that I am responsible for payment of the fully billed amount of charges not paid by my insurance company or its agent within 45 days from the date of their receipt of claim. (In accordance with The Texas Insurance Code and Department Rules, Articles 3.70-3C, Section 3A and 20 A.18B and in the Texas Administrative Code Sections 21.2801 – 21.815).**

A fee of $240 is charged for a missed appointment ("no show") with a Nurse Practitioner or Physician's Assistant (45 minutes), $120 is charged for a missed medication appointment (15 minutes), and $90 for a missed appointment with a Licensed Professional Counselor unless cancelled 24 hours in advance. The same fees will be charged for late cancellations. A fee of $320 is charged for new patient no shows/late cancellations with a Nurse Practitioner or a Physician's Assistant. A fee of $120 is charged for new patient missed appointments or late cancellations with a Licensed Professional Counselor. I understand that the current debit/credit card on file may be used to pay such fees.

_____ _____

SIGNATURE OF PATIENT **Date**

I consent for the employees at APN Behavioral Healthcare to leave a confidential, detailed voicemail message at the following phone # _____ (If you do not consent, PLEASE DO NOT fill in the phone #).

Type of Credit/Debit Card: (please circle one):

Master Card Visa

Name of Cardholder (Printed)/Signature _____

Credit Card Number: _____

Expiration Date: _____

Security Code: _____

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THE USAGE OF MEDICATIONS

There are times we prescribe medications which are not labeled specifically for usage in a particular condition. This is because the U.S. Food and Drug Administration (FDA) indications for any given drug are based on their review and acceptance of studies which have been submitted to them for usage in specific diagnoses rather than symptoms. Medications treat symptoms, not diagnoses. There are times when a medication is found to be useful for one symptom or disorder, but clinical experience reveals that it is also useful in other areas. When this occurs, pharmaceutical companies occasionally conduct new medication trials to seek additional FDA approval. This pursuit of "indication for use" from the FDA is a business decision that many pharmaceutical companies decide not to make because of the extremely high cost of medication research and testing and the fact that the medication has already received approval for prescribing. Most pharmaceutical companies decide to rely upon providers learning the additional uses through articles published in medical journals, professional educational forums, and collegial networking. The usage of medications without FDA indication for a certain condition is referred to as "off-label" use.

There are special circumstances regarding children. All medications are "approved by the FDA" for a specific marketed indication based on registration trials and clinical trial research. Most of all, the medications that pediatric providers use are used "off-label." Considering the complications of testing medication on children (a child cannot sign a waiver stating that he / she understands the risks of being involved in medication research), there are few medications that are "approved" by the FDA for children. An example of an "off-label" use of medication with which you might be acquainted would be amoxicillin. Amoxicillin was widely used with adults, and its success in treating infection led to its almost immediate embrace by pediatric providers. Because it was already being used with children, the manufacturer never sought an approved indication and, to this day, amoxicillin is not "approved" by the FDA for use in children, although its use is nearly universal.

It is important for you to understand that the medications we recommend and prescribe have been shown to be helpful in the hands of many providers. We want you to be informed of the possible benefits and side effects of these medications and encourage you to read all you can and ask any questions that you have. We are committed to pursuing a plan of action, which leads to the lowest dosage of medication and the smallest number of medications used, consistent with optimal level of wellness. Our goal for the medication we prescribe is to treat and reverse as many symptoms as possible while pursuing additional non-medication strategies. Counseling and lifestyle changes can further add to recovery from the presenting symptoms in the short-run. This will also enable the medication itself to work more effectively and may, in the long run, possibly negate the need for some, or all, of the medications originally prescribed.

Please feel free to express concerns or questions you may have during your visit. We endeavor to provide you all the information we can to help you make informed decisions concerning you or your child's care.

_____
PLEASE PRINT PATIENT NAME

_____ _____
SIGNATURE OF PATIENT (IF 16 OR OLDER) Date

_____ _____
SIGNATURE OF PARENT OR LEGAL GUARDIAN Date

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MEDICATIONS LIST

Please list all psychiatric medications with dosage that you or, the patient, if that is not you, have been prescribed prior to becoming a patient at APN Behavioral Healthcare. Along with the medication name, include start and end dates, and why the medication was discontinued. These medications **DO NOT** include the psychiatric medications you have been prescribed by our providers here at APN Behavioral Healthcare.

1. _____ _____ _____
Medication/dosage **Start Date** **End Date**
_____
Reason you stopped the medication

2. _____ _____ _____
Medication/dosage **Start Date** **End Date**
_____
Reason you stopped the medication

3. _____ _____ _____
Medication/dosage **Start Date** **End Date**
_____
Reason you stopped the medication

4. _____ _____ _____
Medication/dosage **Start Date** **End Date**
_____
Reason you stopped the medication

5. _____ _____ _____
Medication/dosage **Start Date** **End Date**
_____
Reason you stopped the medication

6. _____ _____ _____
Medication/dosage **Start Date** **End Date**
_____
Reason you stopped the medication

7. _____ _____ _____
Medication/dosage **Start Date** **End Date**
_____
Reason you stopped the medication

8. _____ _____ _____
Medication/dosage **Start Date** **End Date**
_____
Reason you stopped the medication

9. _____ _____ _____
Medication/dosage **Start Date** **End Date**
_____
Reason you stopped the medication

10. _____ _____ _____
Medication/dosage **Start Date** **End Date**
_____
Reason you stopped the medication

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Telemedicine/Telehealth Consultations:

I understand that telemedicine/telehealth consultations may be a part of my treatment at APN Behavioral Healthcare. The purpose is to assess my mental health. This is done through a two-way audio/video link up with a healthcare provider for APN Behavioral Healthcare.

I understand that:

1. My healthcare provider and I, or both of us, will talk through the audio/ video link with the healthcare provider for APN Behavioral Healthcare.
2. I understand that this procedure will be done through a two-way audio/video link. I know it will be equal to a face-to-face visit with a healthcare provider.
3. I understand that there are possible risks with the use of this new technology.
   These include, but are not limited to:
   - Interruption or disconnection of the audio/video link
   - A picture that is not clear enough to meet the needs of the consultation.
   - The audio/video link is conducted through the Internet. There is a small chance that someone could hack into the consultation.
4. I authorize the release of any relevant medical information that pertains to me to the healthcare provider for APN Behavioral Healthcare or their agents. This information may include my name, age, birth date, or other information that is necessary to conduct this telemedicine/telehealth consultations.
5. I understand that this consultation will become part of my medical record kept by APN Behavioral Healthcare.
6. I understand that I must give my informed consent to participate in this consultation.

_____

Patient Name (Please Print)

_____ _____

Patient or Parent/Guardian Signature **Date**

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Medication Management Telemedicine Appointment Protocol for Patients

A telemedicine appointment is at the discretion of the provider, and if a provider deems that telemedicine appointments are no longer appropriate, they will no longer be available to said client. This appointment should be treated like any other office visit:

_____ 1. A client may have to wait, as they might if sitting at the physical clinic.

_____ 2. A client should be dressed appropriately and should be immediately available for appointment when the provider attempts to contact them.

For a client to be seen via telemedicine for a medication management appointment, they must agree to:

_____ 1. Being in a quiet, isolated place where HIPPA LAWS are protected.

_____ 2. Being completely and appropriately dressed.

_____ 3. Must be sitting upright unless they are physically incapable of doing so.

A telemedicine appointment will be cancelled at the expense of the client for the rate of a no show/late cancellation fee and may be cancelled by the provider for the following reasons:

_____ 1. If a client does not answer after contact has been attempted twice

_____ 2. If a client is not readily available for their appointment, and a family member is trying to search for them

_____ 3. If a client is driving a motor vehicle

_____ 4. If a client is in a public, non-isolated location

_____ 5. If a client is not appropriately dressed

If any of these reasons are deemed as not acceptable to a client, they must come in for a physical office visit.

_____ _____

Signature Date

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Medication Management Telemedicine Appointments 3 Month Requirement

In order to meet Texas requirements for medication management telemedicine appointments, you must come in to have your vitals checked at least once every 3 months. However, if you are unable to do so due to distance or extenuating circumstances, you may see your primary care physician (PCP) and have their office send us your vitals on their letterhead prior to your 3 month appointment. Your 3 month appointment will be considered a no show, and you will not be seen, if we have not received this information from your PCP prior to the 3 month appointment.

_____ _____

Signature Date

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Lindsay Whitman, LPC

Informed Consent

This document contains important information about my professional services and business policies. Please let me know if you have any questions or concerns regarding any of the following policies.

Qualifications

I am licensed by the state of Texas as a Licensed Professional Counselor (72919). I have a Bachelor of Science in Psychology from Texas A&M University, College Station, Texas and a Master of Arts in Clinical Psychology from Sam Houston State University, Huntsville, Texas.

Counseling Purposes, Goals and Techniques

A licensed professional counselor (LPC) is a mental health professional who provides professional therapeutic services to individuals and groups that involve the application of mental health, psychotherapeutic, and/or human development principles to facilitate adjustment and development throughout life. The purpose of counseling is to enhance your personal growth and your ability to cope with life's problems. I am trained in a variety of counseling techniques from which I will tailor your treatment plan based on your treatment goals.

I believe the key to growth and success in therapy is the individual's commitment to the process and the relationship between the individual and the counselor. Therapy involves a large commitment of time, money, and energy. I recommend consistency to provide continuity and momentum for growth and change.

Your Counseling Records

Your records will be kept on file for 5 years and will only be available to the counselor and her staff who have need for it. Your records may be shared with another professional or agency which referred you and/or to which you agree to be referred. Your case may be discussed anonymously with other professionals only for consultation purposes.

Confidentiality and Required Reporting

The Texas Health & Safety Code states that communication between the therapist and client as well as the client's records is confidential. There are some limits to confidentiality and these include:

1. I am required to report suspected abuse or neglect of minors, elderly or disabled persons.
2. I may take reasonable action to inform medical or law enforcement personnel if I determine that there is a probability of imminent physical injury by the client to the client or others.
3. I may receive a court order in legal matters.
4. Your insurance provider will require information such as a diagnosis and dates of service in order to utilize your mental health or EAP benefits.
5. I am required to report suspected sexual exploitation by a mental health service provider.
6. I am required to report suspected abuse, neglect, and illegal, unprofessional, or unethical conduct in an in-patient mental health facility, a chemical dependency treatment facility or a hospital providing comprehensive medical rehabilitation services

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Emergencies

If you have an emergency that puts your physical safety at risk, please call 911.

Complaints

If you have a complaint that you feel we are unable to resolve, you may contact the Texas State Board of Examiners of Professional Counselors at 1-800-942-5540 or write them at Texas State Board of Examiners of Professional Counselors, MC 1982, PO Box 141369, Austin, Texas, 78714-1369.

Distance Counseling

Distance counseling, also called telemental health, telepsychology, telehealth, or online therapy, is defined as counseling using electronic, telephone, or audio/visual telecommunications.

Distance Counseling Options Offered & Client Privacy

I, the client, understand that Lindsay Whitman and APN Behavioral Healthcare currently offer distance counseling via phone and audio/visual telecommunication. They offer these audio/visual telecommunication options: Doxy.me, Skype, or Facetime. I fully understand that neither Skype nor Facetime is a guaranteed format for client confidentiality. I understand that telephone is not HIPPA protected.

Technology Failure

I, the client, do understand that in the event of a technology failure during an audio/ visual telecommunication session, immediate steps will be taken by the therapist to reconnect. Contact via phone is the first backup step to failed phone and audio/visual telecommunication reconnection. The therapist will repeatedly attempt to use these methods to contact me through the next 15 minutes or until the remaining session time is not ample enough time for a full therapy session (and I will do the same, as well).

Recording of Sessions

I understand that audio/visual or phone sessions will not be recorded, unless there is an explicit written consent by me for reasons that clearly benefit my treatment.

I understand that I have the option to choose the methods of telecommunications that I prefer and that I must "opt in".

Check all that apply:

Distance Counseling Using Visual Telecommunication

____ I give my consent to use Skype for my distance counseling.

____ I give my consent to use FaceTime for my distance counseling.

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____ I give my consent to use Doxy.me for my distance counseling.

Distance Counseling Using Phone: My Consent

____ I give my consent to use the telephone for my distance counseling.

- I have had ample opportunity to ask questions and receive clarification about these options and this policy.
- I will comply with the above plans set up to address the potential risks of distance counseling and discuss any aspects that require my participation in the planning.
- I understand that I have the option to choose which telecommunication method(s) I prefer
- I have "opted in" for the electronic technology that is acceptable to me at this time.
- I understand that I have the option to change my mind about any of my choices listed above and I will do so in writing.
- I do recognize the potential risk of compromise to my confidentiality by using phone or visual telecommunication.
- I wish to proceed knowing these risks.

Consent to Treatment

I have read or have had satisfactorily explanations and I understand this disclosure of information, policies and client agreement. Any questions that I had about this statement including fees and payment policies have been answered and explained to my satisfaction (for client under the age of 18, consent must be given and this form must be signed by either a parent or legal guardian). I understand and agree to the description of confidentiality and the exceptions as stated above. I consent to counseling under the terms described above. My signature below indicates that I have received a copy of this form.

_____

Client Name

_____

Signature (Client or Guardian)

_____

Date

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HEALTH INFORMATION PRACTICES
Effective 04/14/2003
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED & DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

UNDERSTAND YOUR HEALTH RECORD INFORMATION

This notice describes the practice of APN Behavioral Healthcare and that of its providers with respect to your protected health information (PHI) created while you are a patient at APN Behavioral Healthcare. The APN Behavioral Healthcare provider and personnel authorized to have access to your medical chart are subject to this notice. In addition, we create a record of the care and services you receive at APN Behavioral Healthcare. We understand that Medical information about you and your health are personal. We are committed to protecting medical information about you. This notice applies to all the records of your care at APN Behavioral Healthcare. The notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

Your Health Information Rights

Although your health record is the physical property of APN Behavioral Healthcare, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information for treatment, payment, healthcare operations and as to disclosures permitted to persons, including family members involved with your care as provided by law. However, we are not required by law to agree to a requested restriction.
- Obtain a paper copy of this notice of information practices.
- Inspect and request a copy of your health record as provided by law.
- Obtain an accounting of disclosures of your health information as provided by law.
- Request communication of your health information by alternative means or at alternative locations. We will accommodate reasonable requests.
- Revoke your authorization disclose health information except to the extent that action has already been taken.

You may exercise your rights set forth in this notice by providing a written request, except for requests to obtain a paper copy of this notice, to the Practice Administrator at APN Behavioral Healthcare.

Our Responsibilities:

In addition to the responsibilities set forth above, we are also required to:

- Maintain the privacy of your health information.
- Provide you with a notice as to our legal duties and privacy practices with respect to information we maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction on certain uses and disclosures.
- We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain, including information created or received before the change. Should our information practices change, we are not required to notify you, but we will have the revised notice available at your request. We will not use or disclose your health information without your written authorization, except as described in this notice.

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Examples of Disclosures for Treatment, Payment, Health Care Operations and As Otherwise Allowed By Law

The following categories describe different ways that we use and disclose medication information. For each category, we will explain what we mean and give some examples. Not every use or disclosures in a category will be listed. However, all of the ways we are permitted to use and disclose information should fall within one of the categories.

We will use your health information for treatment. For example: We may disclose medical information about you to your primary care physician or subsequent health care providers with copies of various reports to assist in treating you once you are discharged from APN Behavioral Healthcare.

We will use your health information for payment. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that may identify you, as well as, your diagnosis.

Business Associates: There are some services provided in our organization through agreements with business associates. Examples including copying services, accounting services, computer services, etc. To protect your health information, however, we require business associates to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representatives, or another person responsible for your care, your location and general condition.

Communications for treatment and health care operations: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may leave appointment reminders on your answering machine or voicemail at home or work, or with a person answering the telephone.

Worker's compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law. For example: You may apply for Disability Insurance Benefits or Life Insurance. Your insurance carrier may request medical information to review your application.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disability.

Abuse, neglect or domestic violence: As required by law, we may disclose health information to government authority authorized by law to receive reports of abuse, neglect or domestic violence.

Judicial, administrative and law enforcement purposes: Consistent with applicable law, we may disclose health information about you for judicial, administrative and/or law enforcement purposes. We will disclose medical information about you when required or allowed to do so by federal, state, or local law.

I acknowledge that I have reviewed and accept the APN Behavioral Healthcare policy regarding Health Information Practices.

_____

PLEASE PRINT PATIENT NAME

_____ _____

SIGNATURE OF PATIENT **Date**

_____

PLEASE PRINT NAME OF PARENT/LEGAL GUARDIAN, IF NECESSARY

_____ _____

SIGNATURE OF PARENT/LEGAL GUARDIAN, IF NECESSARY **Date**

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HEALTH INFORMATION DISCLOSURE

I, _____, authorize APN Behavioral Healthcare and/ or their
(Print Name)
Authorized staff to disclose and provide photocopies of the following protected health information regarding (Check One)
( ) Myself
( ) My minor child over whom I am parent or guardian
( ) My minor child of whom I am the Managing Conservator
( ) Other party of whom I have legal guardianship (Copy of Court Documents Required)

To the following party: _____
_____

Protected medical information I am authorizing for disclosure is: (CHECK ALL THAT APPLY).

___ Psychiatric Evaluation ___ Progress Notes ___ Medication Records ___ Billing Records

___ Treatment Plans or Summaries ___ Hospital Records Created by Barbara Miller ___ Mental Health Records

___ Substance Abuse Records ___ Lab Tests/ Study Results ___ Other (Specify) _____

Purpose of Disclosure: ( ) Request of authorized individual patient
( ) Continuation of care by another clinician
( ) In support of application for insurance
( ) Security Investigation for employment
( ) Insurance review of my claim for services
( ) For Review in a legal matter
( ) To assist in educational and / or employment accommodations

This authorization will be in force and effect until treatment is concluded or until revoked in writing by me via Certified Mail to APN Behavioral Healthcare, 503 West Main Street Waxahachie, TX 75165.

I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient who may not be bound to the same confidentiality standards as my physician, and, therefore, such disclosed information may no longer be protected by federal or state law. I hold APN Behavioral Healthcare harmless for any directly or indirectly from his authorized release of protected health information.

_____ _____
Signature of Patient or Authorized Individual Date

_____
(Print Name)

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PATIENT AUTHORIZATION FOR STUDENT OBSERVATION

APN Behavioral Healthcare participates in clinical degree programs with universities to give master-prepared students experience in clinical practice. Your provider has agreed to permit the Nurse Practitioner students to observe and participate in client appointments.

By signing below, you agree to permit the students working in your provider's office to observe and participate in your healthcare during your appointment today, and future appointments. You agree that you have been given the opportunity to refuse to give such consent and that you may withdraw your consent at any time during your appointment.

_____

Patient Name

_____ _____

Patient Signature Date

IF PATIENT IS UNABLE TO CONSENT OR IS A MINOR, COMPLETE THE FOLLOWING:

This patient, who name is written above, is a minor, ____ years of age or is otherwise unable to consent to and execute this document for the following reason:

_____

I hereby execute this document on the patient's behalf. I have read and fully understand each part of this document. I represent and verify that I am authorized to execute this document on behalf of the patient named above. I understand that I am entitled to receive a signed copy of this document.

_____ _____

Signature of parent/guardian/LAR of minor patient Relationship to patient

_____

Date

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Consent to Treat Minor Children

I, _____, parent or legal guardian of _____, born the _____ day of _____, 20___ do hereby consent to any medical care or treatment provided by APN Behavioral Healthcare and associates to be necessary for the welfare of my child while said child is under the care of _____, _____, _____, _____, _____. I will provide custody paperwork for this child, if applicable.

_____ _____

Print Name of Parent or Legal Guardian Date

_____ _____

Signature of Parent or Legal Guardian Date