Matthew A. Berger, MD, PC

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Phone (570) 346-3686 ● Fax (570) 207-0615

CONSENT FOR TREATMENT

I/We are the parent(s) and/or legal guardian(s) for the minor named below and hereby give consent to the office of Matthew A. Berger, MD, PC to treat (including but not limited to therapy, medication management, psychiatric evaluations, psychological evaluations, educational evaluations, personality testing, and ADHD testing).

Minor's Name (13 or under) _____ **Date of Birth** _____

Parents' Marital Status

☐ **Other**

☐ **Never Married*** Both natural parents' signatures required

☐ **Married** Both parents' signatures required

☐ **Separated*** Both parents' signatures required

☐ **Divorced***

- ☐ I represent that I have **Sole Legal Custody** and authority to make medical and psychiatric treatment decisions.
- ☐ I represent that I have **Joint Custody** and authority to make medical and psychiatric treatment decisions.
- ☐ I represent that I have **Shared Custody** (Both parents' signatures required unless custody agreement or court order provided.)

Mother or Legal Guardian (printed)	Father or Legal Guardian (printed)	Witness (printed)
Mother or Legal Guardian Signature	Father or Legal Guardian Signature	Witness Signature
Date	Date	Date

***Please bring a signed copy of your custody agreement to your initial appointment .**