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

☐	**Not Married***	At least one natural parents' signature required or follow the Custody Order
☐	**Married**	At least one parents' signature required
☐	**Separated***	Both parents' signatures required
☐	**Divorced***	

- ☐ I represent that I have **Sole Legal Custody** and authority to make medical and psychiatric treatment decisions (only one signature required)
- ☐ I represent that I have **Joint/Shared Custody** and authority to make medical and psychiatric treatment decisions. (Both parents' signatures required)
- ☐ **Court Order for treatment** (Only one signature of parent/guardian attending visit required)

Legal Guardian (signature)	Legal Guardian (printed)	Relationship	Date

Legal Guardian (signature)	Legal Guardian (printed)	Relationship	Date

Witness (signature)	Witness (printed)	Date

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