TRIAD PSYCHIATRIC AND COUNSELING CENTER, P.A.

603 Dolley Madison Road Ste. 100
Greensboro, NC 27410
TELEPHONE (336) 632-3505
FAX (336) 632-3503

CONSENT BY PARENT OR GUARDIAN TO TREAT A MINOR CHILD

DATE: _____/_____/_____

I, _____, am the parent or guardian of _____, DOB:_____/_____/_____,and do consent to treatment of the above named minor by TRIAD PSYCHIATRIC AND COUNSELING CENTER, PA. This treatment may include but is not limited to: medication management, therapy, or other services deemed appropriate by the minor's clinicians.

I further state that there are no Court Orders or Guardianship Agreements in place for the above named minor, which may supersede this agreement in a court of law.

I am signing this form under no duress and in the presence of a witness to hold Triad Psychiatric & Counseling Center, PA harmless in any question of unauthorized treatment of the above named minor.

PARENT (GUARDIAN) NAME: _____

PARENT(GUARDIAN) SIGNATURE: _____

WITNESS NAME: _____

WITNESS SIGNATURE: _____