

Consent to Treat a Minor & Consent to Treat a Minor without a Parent or Legal Guardian Present

Patient Name: Date of Birth:

This consent allows a minor to be seen by a provider with Barnabas Behavioral Healthcare, LLC when a Parent or Legal guardian is unable to go with them to a visit. The Parent or Legal guardian must fill out and sign this consent form. If this consent form is not initialed and signed, treatment may not be given to the minor. The provider has the right to cancel or reschedule the appointment until the Parent or Legal guardian is with the minor if it is in the best interest of the minor patient or is required by law. In most cases, informed consent must be given from the minor's parent or legal guardian.

- Under South Carolina law, any minor who has reached the age of 16 years may consent to any nonsurgical treatment.
- A separate and valid (legal) permission form is needed to get medical records which belong to a minor. It is called an Authorization for Release of Health Information (ROI) form and can be provided by the practice or found at www.barnabashealthcare.com This form is required by law and must be completed to get copies of the medical record.

For new patients: All patients under 18 years of age must have a Parent or Legal guardian with them for their first visit (physical and/or telehealth). If not, they will be asked to reschedule the appointment and applicable fees will assessed and invoiced.

Please initial below. This is a required permission. Signature on Following Page

I give Barnabas Behavioral Healthcare, LLC permission to treat my child.

This treatment may include, but is not limited to:

Psychological Testing Counseling Patient Education Psychiatric Treatment/Examination Medication Management Biofeedback



## The two sections below are optional and not required. Please initial below if appropriate and/or mark through sections you do not need or are unapplicable.

\_\_\_\_\_ I hereby give Barnabas Behavioral Healthcare, LLC permission for the authorized named person (listed below) to go with my child to the visit. This authorized person must be 16 years of age or older.

Name of Authorized Person	
Relationship to Patient	
Name of Authorized Person	
Relationship to Patient	
Name of Authorized Person	
Relationship to Patient	

**For established patients 16 years of age and older:** They can be seen for follow up appointments without a parent or legal guardian only if the parent or legal guardian fills out and signs this consent form. This form authorizes Barnabas Behavioral Healthcare, LLC to give treatment to their teen. The provider still has the right to reschedule the appointment if they believe the parent or legal guardian should be at the visit.

\_\_\_\_\_\_ I hereby give permission for my adolescent (who is 16 years or older) to be seen at a Barnabas Behavioral Healthcare, LLC when they arrive at the office alone or through telehealth visits alone.

## Consent:

I have read and fully understand this consent for treatment. By signing below, I consent to medical and/or psychological treatment. This consent will remain valid and enforceable until it is revoked (canceled) or replaced by a new form of consent.

		//
Name of Parent or Legal Guardian	Signature	Date
		//
Name of Parent or Legal Guardian	Signature	Date

## \*\*\*In the event of joint legal custody, both parties are required to sign \*\*\*