Chirayu Neuropsychiatry Medical Center
Gyan Psyche
Mental Health Services
12, SANT RAGHUVAR NAGAR, SIGRA
VARANASI (221010)

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INFORMED ASSENT & CONSENT FORM FOR MINORS (ONLINE)

Section 1: For the Minor (Child/Adolescent)

You will be meeting with a clinical psychologist or psychiatrist at Gyan Psyche. They are here to help you talk about anything that may be bothering you—your thoughts, feelings, or things happening in your life. Sometimes they may also suggest helpful tools or medicines to make you feel better.

Some things you say will stay private between you and your therapist or doctor. But if there is a serious concern about safety, they may need to speak with your parent or guardian to help keep you safe.

You have the right to:

- **Be treated kindly and with respect**
- **Ask questions or say if you don't understand**
- **Say yes or no to talking (with your parent or guardian's permission)**
- **Stop if something feels uncomfortable and talk about it**
- **Be heard without being judged**

If you understand and feel okay to begin, please sign below.

Minor's Name: _____
Age: _____
Signature (if age-appropriate): _____
Date: _____

Section 2: For the Parent or Legal Guardian

I, the undersigned parent/legal guardian, consent to my child receiving psychological and/or psychiatric services through Gyan Psyche. These services are provided online by licensed clinical psychologists and registered psychiatrists.

Nature of Services

Services may include:

- **Psychological therapy (talk therapy, behavior therapy, trauma-informed interventions)**
- **Psychiatric evaluations and diagnostic assessments**
- **Prescription and management of psychiatric medications**
- **Psychoeducation regarding symptoms and mental health conditions**
- **Follow-up consultations and monitoring**
- **Referral for lab tests or investigations if medically indicated (e.g., blood tests, neurological assessments)**

Benefits and Risks

Therapeutic and psychiatric care may help improve emotional, behavioral, and cognitive functioning. Medication may support symptom management. However, therapy can bring up emotional discomfort, and medications can have side effects or require adjustments. No specific outcome is guaranteed.

I understand that clinical decisions (including prescription or referrals for investigations) will be made in consultation with the psychiatrist and based on professional judgment.

Confidentiality

All sessions and medical information will be kept confidential, except in the following cases:

- **If the child is at risk of harming themselves or others**
- **If there is suspected abuse or neglect of a minor or vulnerable person**
- **If disclosure is required by law**
- **If medical emergencies arise during the course of treatment**
- **If a referral is made to another healthcare provider with consent**

Therapists and doctors may share age-appropriate feedback with parents/guardians while maintaining the child's privacy.

Online Care

All services are provided online. I agree to ensure a quiet, private, and secure environment for my child during sessions. Sessions will not be recorded or shared by either party without explicit mutual consent.

Emergency Protocol

I understand that Gyan Psyche is not an emergency or crisis service. In case of immediate danger or a psychiatric emergency, I agree to contact local emergency services or visit the nearest hospital.

Professional Referrals

If the mental health professional determines that your child needs care beyond our scope (such as inpatient care, medical diagnostics, or specialised therapies), we will provide appropriate referrals and guidance.

Parent/Guardian Consent

I confirm that:

- **I have read and understood this form**
- **I give permission for my child to receive psychological and/or psychiatric care**
- **I am aware of the nature, benefits, and risks of therapy and medication**
- **I consent to evaluations, prescription of psychiatric medications, and investigations as needed**
- **I agree to support the treatment process and maintain open communication with the care team**

Parent/Guardian Name: _____
Relationship to Minor: _____
Signature: _____
Date: _____

Therapist/Psychiatrist Name: _____
Signature: _____
Date: _____