SUMMIT CLINICAL SERVICES PC REGISTRATION

For Children/Adolescent Services

Today's Date: _____

Patient's Full Legal Name:
_____
(Last Name) (First Name)

Parent or Legal Guardian 1 Contact Information:

Name: _____
Relationship to Child: _____
Street Address: _____
City: _____ State: _____Zip: _____
Cell Phone: _____
Email Address:_____

Parent or Legal Guardian 2 Contact Information:

Name: _____
Relationship to Child: _____
Street Address: _____
City: _____ State: _____Zip: _____
Cell Phone: _____
Email Address: _____

Relationship of Parents/ Legal Guardians:_____

List Parenting time Arrangements, if any: _____
_____
**Please provide copies of current legal documents in support of the above.

Please initial below (Legal Guardian 1):

_____ **(Initial)** I understand that I need to provide copies of the legal documents in support of the above prior to or at the Initial Consultation.

_____ **(Initial)** I understand that it is my responsibility to provide Summit Clinical Services and my child's treatment team with all updates of legal changes relating to my child, such as legal guardianship, parent/legal guardian medical decision-making rights, parenting time, and living situation.

_____ **(Initial)** I attest that this information is true and complete to the best of my knowledge.

Please read the following closely as it explains pertinent information regarding our policies for minors.

Initial Consultation:

The Initial Consultation is an opportunity for you and the psychiatrist to meet and determine whether there is a good fit and whether she is well suited to safely provide the treatment needed for your child's circumstances in the outpatient setting.

For children and adolescents, the Initial Consultation is typically divided into two separate appointments. At least 1 Parent/Legal Guardian must be present along with the patient for each part of the Initial Consultation. Depending on the circumstances, the doctor may decide to spend most of the first 90-minute appointment gathering information from the Parents and most of the next, separate 90-minute appointment understanding and assessing your child, or vice versa. The goals of the two-part consultation are to develop a therapeutic alliance with the family, to support a comprehensive assessment of your child's mental health needs, and to develop initial treatment recommendations.

Please be aware that the Initial Consultation is not an agreement to begin a treatment relationship. Your child deserves the most appropriate treatment and level of care according to their needs and we understand that may not be with us. Upon conclusion of the Initial Consultation, we can discuss and decide whether to begin a treatment relationship. Given this approach, please be aware that medication may only be considered and/or prescribed after the consultation is complete and a decision is made to begin a treatment relationship. At least 1 Parent/Legal Guardian must be present along with the patient during each follow up appointment.

Before entering into a treatment relationship or at any time during treatment, you or your child's psychiatrist may determine that you are not the right fit for each other. This happens sometimes, and it is ok. Your child's well-being and treatment are the priority. Please let your psychiatrist know how you feel; we can discuss the next best steps such the current assessment and treatment recommendations and the psychiatrist can provide treatment referrals for alternate providers who may be able to better meet your child's treatment needs.

Consent to Treatment:

_____ **(Initial – Legal Guardian 1)** I understand and agree with the above. I provide consent for my child to engage in a psychiatric evaluation and ongoing treatment.

_____ **(Initial – Legal Guardian 2)** I understand and agree with the above. I provide consent for my child to engage in a psychiatric evaluation and ongoing treatment.

_____ **(Initial – Patient; required for patients age 12 years and older)** I provide assent to engage in a psychiatric evaluation and ongoing treatment.