PATHWAYS
SPECIALTY CLINIC
2219 Sawdust Rd #1004, The Woodlands TX 77380

CONSENT FORM FOR TREATMENT OF MINORS WITH DIVORCED OR SEPARATED PARENTS

Pathways Specialty Clinic will not initiate treatment for minors of divorced or separated parents until the clinic is provided with a copy of a legal divorce decree or custody agreement. Any parents or legal guardians who are listed in the decree as having medical and/or psychiatric decision-making authority must sign this treatment consent form prior to initiating a treatment.

Please initial next to each statement to indicate your understanding and agreement.:

- It is parents and legal guardians' responsibility to adhere to the terms of a legally binding divorce decree. It is NOT the responsibility of the providers at Pathways Specialty Clinic to ensure those directions are being followed.

- Providers of the Pathways Specialty Clinic expect divorced parents to communicate with each other about services recommended and to determine who will schedule appointments, who will bring the child to treatment, who will administer medications, etc.

- Providers and the child will not be messengers between parents.

- Consent for the minor patient's treatment must be given by both parties unless one parent has the full legal custody and Medical decision-making authority. If not, both parents should represent themselves either by being present at the appointment or by one party being present by telephone during the appointment. Providers cannot take time from the child's care to contact parents to obtain consent before, during or after the appointment.

Violation of this policy will result in termination of care.

- Failure of one or more of a minor patient's medical decision makers to agree to the recommended treatment plan will result in the minor patient being discharged from the clinic.

- Your signature indicates that you will not request or require your clinician or others affiliated with Pathways Specialty Clinic, through subpoena, summons, or other means, to provide testimony in any legal proceeding relating to the care and custody of your child. We will not testify in court about custody issues as it is not our role to conduct custody evaluations, determine whether a parent is "fit" to fulfill parental duties.

Statement of Legal Guardian (Primary)

I _____ (legal guardian) give my permission to _____ (other legal guardian) and my child's clinician(s) at Pathways Specialty Clinic to make decisions regarding pharmacologic and therapeutic Interventions, scheduling appointments, and cancelling appointments, if I am not physically present during any appointments.

I accept the responsibility of communicating with _____ (other legal guardian) after every appointment regarding any change in the treatment plan. I understand that my child's clinician will not contact me outside of my child's scheduled appointment time to obtain consent for these changes, however I may contact the clinician if I wish to withdraw consent to a change in treatment regimen.
I understand that failure for myself and my child's other legal guardian to agree to the recommended treatment plan will result in my child being discharged from the clinic.

I understand that if the above policies are violated or I choose not to adhere to these policies, my child will be discharged from this clinic.
I agree that my electronic signature on this application is binding and enforceable, as if I had signed a paper copy.

Patient Name:_____
Date:_____
Legal Guardian #1 Name:_____

Signature:_____

Statement of Legal Guardian (Secondary)

I _____ (legal guardian) give my permission to _____
(other legal guardian) and my child's clinician(s) at Pathways Specialty Clinic to make decisions regarding pharmacologic and therapeutic
interventions, scheduling appointments, and cancelling appointments, if I am not physically present during any appointments.
I accept the responsibility of communicating with _____ (other legal guardian) after every appointment regarding any change in the treatment plan. I understand that my child's clinician will not contact me outside of my child's
scheduled appointment time to obtain consent for these changes, however I may contact the clinician if I wish to withdraw consent to a change in treatment regimen.
I understand that failure for myself and my child's other legal guardian to agree to the recommended treatment plan will result in my child being discharged from the clinic. I understand that if the above policies are violated or I choose not to adhere to these policies, My child will be discharged from this clinic.

I agree that my electronic signature on this application is binding and enforceable, as if I had signed a paper copy.
Patient Name:_____
Date:_____
Legal Guardian #2 Name:_____

Signature:_____