



Credence Therapy Associates

1 ½ West Geneva Street

Elkhorn, WI 53121

(262)723-3424

**Right to Authorize Treatment of Minor**

(Only to be completed if patient is less than 18 years of age)

Name of patient \_\_\_\_\_ Age of patient as of today's date \_\_\_\_\_

Please read the following statements and provide your signature where indicated agreeing that you did review this and understand its contents. If you have any questions, please ask your therapist or any of the office staff to assist you. You will also be given a copy of this document upon request.

1. Relationship to minor child being seen today \_\_\_\_\_ Parent (biological or legal adoption)  
\_\_\_\_\_ Legal Guardian  
\_\_\_\_\_ Other (please explain) \_\_\_\_\_

2. With whom does the minor patient reside \_\_\_\_\_ One parent \_\_\_\_\_ Both parents together  
\_\_\_\_\_ Both parents separately \_\_\_\_\_ Guardian  
\_\_\_\_\_ Other \_\_\_\_\_

3. Is there another person (other than the person completing this form) with Joint Legal Custody of the minor patient?

Y N

- a. If Yes, their name and relationship: \_\_\_\_\_  
b. If Yes, are they aware mental health treatment is being sought for this minor Y N  
c. Have you ever been married to this other person Y N  
d. Are you currently \_\_\_\_\_ married to \_\_\_\_\_ divorced from \_\_\_\_\_ in the process of a divorce with this person.  
e. If divorced or in the process of divorce, is there currently a Guardian AD Litem Y N

If yes, name \_\_\_\_\_

4. If you are a legal guardian (not parent), do you have a copy of the legal paperwork granting guardianship Y N N/A  
(If yes, we will need a copy of the agreement)

5. If you are divorced, do you have a legal custody agreement Y N N/A  
(If yes, we will need a copy of the agreement)

6. If you are in the process of divorce, do you have a temporary legal custody agreement? Y N N/A  
(If yes, we will need a copy of the agreement)

**Attestation of Signor:**

I understand that if I have joint legal custody of a minor child being seen by Credence, and I have indicated that the other parent/guardian is **not** aware of this treatment, that in most cases the other parent/guardian will be contacted to and made aware of the therapy. In doing so we will:

- Attempt to reach that other person with joint legal custody and make them aware of the treatment.
- Attempt to determine that there is no objection to treatment.
- Attempt to determine what level of participation by that person would be in the best interest of the child.

**EXCEPTIONS**

There are exceptions to this notification, which may include inaccessibility of the other person, that person being found guilty of abuse or neglect of the child, or based on any other information that would indicate that such contact would be harmful to the child and the therapeutic process. Please discuss any exceptions that you believe should be made with your child's therapist before completing this form.

Contact information will be assumed to be the same for each parent except for listed differences

Mothers Name \_\_\_\_\_ Fathers Name \_\_\_\_\_

Address: \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Telephone (    ) \_\_\_\_\_ Telephone (    ) \_\_\_\_\_

I have read and understand the information provided in this Treatment Authorization document and if requested, have a received a copy of this document.

*Parental/Guardian Signature*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

*Witness Signature:*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*