Spectrum Psychological Associates, Inc.
Consent to Treat Minor

I/We _____ (Parents and Legal Guardians print your full name(s) on this line), authorize providers of Spectrum Psychological Associates, Inc. (Spectrum) to provide psychological treatment to my/our dependent child, _____ (Print your child's name on this line) whose birthday is _____/_____/_____. I/We authorize Spectrum providers and their designees to perform routine examinations, order or perform diagnostic or routine procedures pertaining to the care and to counsel my/our child. I/We acknowledge that no guarantee or assurance has been made to me/us or my/our child regarding the result of any examination or treatment. In the event of a medical emergency, I/We authorize Spectrum to provide necessary emergency care and transport to my/our child to an affiliating hospital for care, if necessary.

I/We understand that a counselor may meet with my/our minor child individually during a session when I/we am/are not present. I/We also understand that a counselor may discuss some issues with my/our child that are considered confidential. In most instances, Ohio and most other state and federal laws allow the parent/legal guardian to obtain this confidential information because a minor is involved, but in the interests of having my/our child reveal information and obtain help, to the extent allowed by law I/we am/are waiving my/our right to obtain this information. I/We understand that the counselor will inform me/us about any matters pertaining to the minor hurting himself or herself or anyone else, and the counselor may be required by law to report suspected child abuse or neglect to the proper authorities. (Please see the Spectrum Agreement form for more detailed information on this issue.)

When we examine, diagnose, treat or refer your child, we will be collecting what the law calls Protected Health Information (PHI). We need to use this information to decide what treatment is best for your child and to provide treatment to your child. We may also share this information with others who provide treatment to your child or need to arrange payment for your child's treatment, or for other business or government functions. THE NOTICE OF PRIVACY PRACTICES (NOPP) EXPLAINS IN MORE DETAIL ABOUT YOUR CHILD'S RIGHTS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), AND HOW SPECTRUM CAN USE AND SHARE YOUR CHILD'S PHI. PLEASE READ THE NOPP BEFORE YOU SIGN THIS CONSENT TO TREAT. In the future, Spectrum may change how we use and share your child's information, and so we may change our NOPP. If we do change our NOPP, you may get a copy by calling us at (440) 446-9696, or by contacting our Privacy Officer.

After you have signed this Consent to Treat Minor Form for your child, you have the right to revoke it (by writing a letter telling that us you no longer consent) and we will comply with your wishes regarding your child's treatment from that point forward.

CONSENT TO TREAT A MINOR CHILD REQUIRES THE SIGNATURES OF BOTH THE MOTHER AND FATHER UNLESS A COURT BARS ONE OF THE PARENTS FROM HAVING ACCESS TO TREATMENT INFORMATION.

I/WE HAVE READ THIS ENTIRE FORM AND I UNDERSTAND ITS CONTENT. I/WE HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THIS FORM AND I/WE HAVE HAD THE QUESTIONS THAT/WE HAVE ASKED SATISFACTORILY ANSWERED. I/WE HEREBY ACKNOWLEDGE THAT I/WE HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES.

_____/_____/_____ _____
Date Mother's Signature

_____/_____/_____ _____
Date Father's Signature

_____/_____/_____ _____
Date Child's Signature (only in states where required by law)

PLEASE INITIAL THE LINE BELOW:
____ I/WE HEREBY ACKNOWLEDGE THAT I/WE HAVE BEEN OFFERED A COPY OF THE SPECTRUM PRACTICE BROCHURE.

NAME OF EMERGENCY CONTACT: _____ List all appropriate phone numbers for your emergency contact:
Work _____
Home _____
Cell _____
Other _____

Relationship of Emergency Contact to Patient: spouse, child, sibling, parent, friend or if other, please list relationship:
_____

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