Child/Minor Consent Form Packet

Welcome | Child/Minor Consent Form | Telehealth Consent Form | Standard Authorization Form | HIPPA and Checklist

Child/Minor Demographic Information

First Name (Client/Patient)* | M.I. | Last Name* | Nickname

Date of Birth* (MM/DD/YYYY) | Gender* (Select One)

Address Line 1* | Address Line 2

City* | State* (Select One) | Zip*

Guardian #1

First Name* | M.I. | Last Name* | Relation to Client*

Phone (Primary)* ((###) ### ####) | Phone (Alternate) ((###) ### ####) | Email Address

Address (Same as Client/Patient)
○ Yes ○ No

Emergency contact
○ Yes ○ No

Responsible for Insurance
○ Yes ○ No

Legal Rights: Does guardian 1 have legal rights and documentation to sign consent for treatment of this minor?
○ Yes ○ No
If yes, please upload related documentation at the bottom of this page.

Guardian #2

○ Yes ○ No

Other Person for Legal Rights

First Name* | M.I | Last Name* | Relation to Client*

Phone Number* ((###) ### ####) | Email

Insurance Information

Patient Photo ID
Choose File | No file chosen

Insurance Card
Choose File | No file chosen

Primary Insurance* (Select One) | Subscriber ID* | Group Number*

Policy Holder First Name* | M.I. | Policy Holder Last Name* | DOB of Policy Holder*

Secondary Insurance (Select One) | Subscriber ID* | Group Number*

Policy Holder First Name* | M.I. | Policy Holder Last Name* | DOB of Policy Holder*

Person responsible for payment (if not client)

First Name | M.I. | Last Name | Relation to Client

Phone Number ((###) ### ####) | Email | Address Line 1

Address Line 2 | City | State (Select One)

Zip

Primary Care Provider

First Name* | M.I. | Last Name*

Location* | Phone ((###) ### ####)

Form Completed by

First Name* | M.I. | Last Name* | Date* (MM/DD/YYYY)

Signature of Client/Patient/Legal Guardian*

Clear

Signature of Insurance Policy Holder*

Clear

Date of Signature* | **Date of Signature***

Upload Documents (Supported files .pdf, .jpg, .jpeg, .png)

Drag and Drop Files Here
Or
Browse

Start Over | Previous | Next