Patient Name _____DOB_____

Consent for Treatment of Minor

I am the legal guardian or legal representative of the patient and on the patient's behalf legally authorize Dr. Libus to deliver mental health care services to the patient. I also understand that all policies described on website LIBUSMD.COM apply to the patient I represent.

I accept, understand and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or treatment of my child. I understand that I may withdraw from treatment at any time.

Name of parent (please print) _____

Parent/Legal Guardian Signature: _____Date:_____

Psychiatrist/Witness: _____ Date:_____