



Fortis Behavioral Health
220 Wintergreen Dr., Suite B
Lumberton, NC 28358
910-536-1719
910-668-8048

PARENTAL CONSENT FOR MENTAL HEALTH TREATMENT OF A MINOR

Parent or Guardians name: _____

Childs Name: _____

Date of Birth: _____

As the parent(s) or legal guardian(s) with the authority to consent on behalf of the minor child named above, we/I hereby give our/my consent for the minor to the rendering of counseling, psychotherapy, psychological assessment, psychiatric care, and medication management by Deana H. Flynn, MSN, PMHNP-BC, as may, in her professional judgment be necessary.

We/I hereby acknowledge that no guarantees have been made to us/me as to the effect of such examinations or treatment on my child's condition. We/I understand that there are inherent risks in pharmacologic treatment and that there may be adverse side effects and results that are not anticipated. We/I consent to treatment of our/my minor child or ward with knowledge of possible risks and understand that we/I will be informed of possible adverse effects when applicable.

This consent will be valid until the minor reaches the age of 18, but can be revoked at any time by written notification provided to Fortis Behavioral Health in person or via the patient portal from the parent or guardian.

We/I acknowledge that we are (I am) responsible for all reasonable charges in connection with care and treatment rendered during this period.

We/I have read this form and certify that we/I understand its contents.

We/I here by give our (my) consent to Deana H. Flynn.

Parent/Guardian Signature: _____

Date: _____

Name of SIGNER: _____

Relationship to patient: _____