**BEHAVIORAL HEALTH SPECIALISTS, INC.**
**900 West Norfolk Avenue, Suite 200**
**Norfolk, NE 68701**
**(402) 370-3140**

# PARENT/GUARDIAN CONSENT TO TREAT

I, _____, as the **(check one)** ☐ parent ☐ legal guardian of _____, hereby give my consent for this individual to be seen by the professional staff of Behavioral Health Specialists, Inc. If this individual is being seen for psychiatric services, this may include receipt of sample medications and/or prescription for medication(s). I understand that there are fees for the services, and I agree to provide the appropriate information for billing the insurance company, Medicaid, and/or Medicare.

***NOTE*: Legal guardian must provide documentation of this designation.**

Signed: _____ Date: _____

Address: _____

_____

Phone: _____ Witness: _____