Four Points Counseling Center

Direction for Treatment of Minors

Client Name: _____ Date of Birth: _____

Relationship to Client

[] Self (client is age 12+) [] Parent* [] Legal guardian [] Department of Human Services

**Biological, adoptive or foster parent with legal rights*

Has legal action been taken that impacts decision-making for the minor client?*

[] Yes [] No

This may include but is not limited to legal separation or divorce, determination of custody and/or guardianship, limitation or termination of parental rights, actions related to paternity, and proceedings regarding participation in mental health services.

*If you indicated No, please skip the section below titled Medical Decision-Making.

Medical Decision-Making

Do legal documents exist that address the following for the minor client:

Medical decision-making authority? [] Yes [] No

Participation in mental health therapy or other mental health services? [] Yes [] No

Payment for medical treatment and/or mental health therapy services? [] Yes [] No

Required Documentation

If indicated below, documented verification of legal authority to make medical and/or mental health care decisions on behalf of the minor client must be provided before the client can be seen for services. Please read carefully.

Signing Individual	Is documentation required?
Minor client age 12+	Not required
Biological/adoptive parent with no legal action impacting decision-making	Not required
Biological/adoptive parent **with legal action** impacting decision-making authority	Documentation required
Adult who is **not** the biological/adoptive parent	Documentation required

Example documentation: Separation agreement, divorce decree, medical/mental health care power of attorney, emergency guardianship order, other court order

Other Authorized Individuals

Please list full names of all additional individuals with medical decision-making authority for the minor client.

_____

Attestation

By signing this document, I attest that the information I have entered is accurate and I have not knowingly omitted information from this form.

I attest that I have legal decision-making authority related to medical, mental health and/or substance use treatment for the minor client named on this form.

_____ _____ _____

Printed Name Signature Date