Sage Neuroscience Center

CONSENT FOR TREATMENT OF A MINOR

I (We) _____ agree to the practice policies of

Sage Neuroscience Center (as laid out in Practice Policies) for the treatment of my minor

child _____ with the following additional items:

- Information gained from sessions will be shared between patient (minor) and parent(s)/guardian(s) listed on this form only.
- Each session may consist of time spent in part with patient only and in part with patient and parent(s)/guardian(s).
- Information gained from session with patient-only that is not directly linked to emergencies, dangerousness to self or others, or crucial aspects of care given by parent(s)/guardian(s), will not be shared with parent(s)/guardian(s) without the patient's consent (verbally or written).
- Most psychiatric medications prescribed for minors have not been FDA approved for treatment ("off label use") of minors due to ethical/logistic concerns of pharmaceutical manufacturers, but will be used based on consensus opinion of practicing psychiatrists working with children and adolescents.
- Psychiatric medications prescribed will be approved by all parties involved: the doctor, the patient, and parent(s)/guardian(s).

By signing this form, I authorize Sage Neuroscience Center and its providers to recommend and prescribe treatment for my minor child. I understand that "off label use" of medications carries inherent risks and I have discussed these with the doctor. I also realize I retain the right to refuse medication at any time. I also acknowledge stopping medication carries inherent risks, and I will discuss this with the doctor before doing so.

Minor Sign	Name	Date
Parent/Guardian Sign	Name	Date
Parent/Guardian Sign	Name	Date
Provider Sign	Name	Date