

BEHAVIORAL HEALTH SPECIALISTS, INC.
900 West Norfolk Avenue
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 person to be seen by the professional staff of Behavioral Health Specialists, Inc.

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: _____