Psychological Solutions, LLC
Minor Consent Form in the Absence of Parental Consent
(to be signed by anyone ages of 14 to 17 years of age in Ohio)

Although **Psychological Solutions, LLC** encourages parental involvement and the participation of your parent/legal guardian in all decisions relating to your care and treatment, we recognize your right to act on your own behalf, and to acknowledge your consent to participate in treatment under a special provision of Ohio law, found at Section 5122.04 of the Ohio Revised Code.
I _____, (print your name), a minor, hereby consent to confidential outpatient mental health services for up to six (6) sessions, or thirty days of treatment, whichever first occurs, and I understand that medication cannot be prescribed to me in connection with this treatment.

In the event of a medical emergency, I authorize **Psychological Solutions, LLC** to provide necessary emergency care and to transport me to an affiliating hospital for care, if necessary. I understand that if that happens, an attempt will be made to contact a parent or guardian.
I also understand that if the counselor knows or suspects that I have suffered or face a threat of suffering any physical or mental wound, injury, disability or condition of a nature that reasonably indicates abuse or neglect of me, that the counselor is generally required to immediately report that to the public children services agency or a municipal or county peace officer in the county in which I reside or in which the abuse or neglect is occurring or has occurred. In addition, if the counselor determines that there is a compelling need for disclosure based on substantial probability of harm to me or to other persons, the counselor may inform my parent or guardian after notifying me that he or she is going to inform my parent or guardian about this information. Parental involvement is encouraged by **Psychological Solutions, LLC** so it always remains your option to involve your parent at any time.

Date: ____/____/____

Signature of Patient:
_____

Printed Name of Patient:
_____