KINDER
KONSULTING

PSYCHIATRIC CONSENT PACKET

CLIENT NAME: _____

DOB: _____

CLIENT ID: _____

PSYCHIATRIC TREATMENT AGREEMENT

TREATMENT GUIDELINES AND PARAMETERS

By my signature and initials below, and as an inducement to Kinder Konsulting and Parents Too, Inc. to provide services to my minor child described above, I hereby represent and consent as follows:

- I understand and agree that my child will be seen by Dr. Samuel McClure and/or Dr. Rakhee Ward at Kinder Konsulting & Parents Too only for the duration of my child's treatment by a Kinder Konsulting Clinician
- I understand and agree that at such time as my child's sessions end with the Kinder Konsulting Clinician, I will need to find another psychiatrist to continue psychiatric treatment.
- I understand and agree that Dr. Samuel McClure and Dr. Rakhee Ward are unable to mail out a prescription for my child. If an appointment is missed, the medication will not be refilled until the next appointment with the doctor.

I understand and agree that Dr. Samuel McClure and Dr. Rakhee Ward are contracted employees of Kinder Konsulting & Parents Too. They maintain their own practices at separate locations, and only provide services at Kinder Konsulting on a limited basis. As such, appointments are only available on a bi-monthly or monthly basis.

PSYCHIATRIC NO SHOW POLICY

STATEMENT: Regular attendance is required in order for our psychiatric services to be effective. Irregular attendance also costs the program time and money. It is therefore the responsibility of the parent or his/her legal guardian that the client attends all their scheduled clinic appointments.

1. You are required to give 24 hours' notice when cancelling or re-scheduling a clinic appointment, otherwise this will be considered a "No Show". Being consistently late for your scheduled appointments is also considered a "No Show".

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2. After the second "No Show" (within a 12-month period), you will be required to seek psychiatric services through another agency/doctor and your clinic case will be closed.

3. After the third "No Show" (within a 12-month period), you will be required to seek psychiatric services through another agency/doctor and your clinic case will be closed.

I UNDERSTAND THE KINDER KONSULTING & PARENTS TOO PSYCHIATRIC NO SHOW/CANCELLATION POLICY AND AGREE TO THESE TERMS.

_____ Initial — I understand that I am responsible to collect my child's vitals information (height, weight, blood pressure) before the appointment with the doctor.

Yes: ☐ **No:** ☐ Kinder Konsulting may send me appointment reminders via text.

Yes: ☐ **No:** ☐ I have the legal right to authorize treatment for my child described above.

Signature of Parent/Legal Guardian: _____

Name of Parent/Legal Guardian: _____ **Date:** _____

Email of Parent/Legal Guardian: _____ **Cell:** _____

Signature of Witness: _____

Name of Witness: _____ **Date:** _____

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PSYCHIATRIC CONSENT PACKET

CLIENT NAME: _____

DOB: _____

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PSYCHIATRIC MEDICATION AGREEMENT

By my signature and initials below, and as an inducement to Kinder Konsulting and Parents Too, Inc. to provide services to my minor child described above, I hereby represent and consent as follows:

- I understand that Dr. Samuel McClure and Dr. Rakhee Ward are not employees of Kinder Konsulting & Parents Too, but instead contract with Kinder Konsulting to provide psychiatric services. I understand that Dr. McClure and Dr. Ward maintain their own practices at separate locations. As such, issues related to their services that arise after the scheduled appointment at Kinder Konsulting, must be directed to the prescribing doctor. Phone Dr. McClure at 321-543-9131 and Dr. Rakhee Ward at 808-499-4447.

- I understand that I must direct any questions or concerns regarding the medication for my child and any possible side effects arising from administering any medication prescribed by Dr. Samuel McClure to Dr. McClure at 321-543-9131.

- I understand that I must direct any questions or concerns regarding the medication for my child and any possible side effects arising from administering any mediation prescribed by Dr. Rakhee Ward to Dr. Ward at 808-499-4447.

- I understand that I am not to contact Kinder Konsulting regarding any issue relating to my child's medication unless it pertains to insurance authorizations.

- I understand that in the even that I am unable to reach the prescribing doctor, and my child is experiencing a side effect from a medication that was prescribed by Dr. McClure or Dr. Ward, that I am to seek immediate medical attention from my child's physician or call 911.

- I understand that Dr. McClure and Dr. Ward will not prescribe/or continue to prescribe medications for my child if I do not complete the Laboratory and Diagnostic service order.

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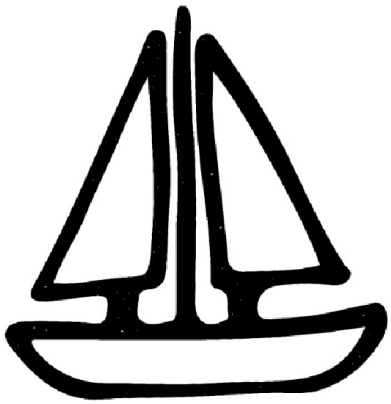
A staff member from Kinder Konsulting & Parents Too has fully explained to me the above procedures, and I have a complete understanding of the information on this form.

By signing below, I agree that I will administer my child's prescription by the directions provided by the physician.

Yes: ☐ **No:** ☐ I have the legal right to authorize treatment for my child described above.



Signature of Parent/Legal Guardian: _____

Name of Parent/Legal Guardian: _____ **Date:** _____

Email of Parent/Legal Guardian: _____ **Cell:** _____

Signature of Witness: _____

Name of Witness: _____ **Date:** _____