Consent for Treatment of Minor Child

LOGAN HEALTH

I, being the parent/guardian of the following patient:

_____ _____

Minor Patient Name Date of Birth

_____ (initials) I do hereby request and authorize any medical provider (physician, physician assistant, nurse practitioner) of Logan Health, and the provider's staff, to perform necessary services for my child, which are deemed advisable by the provider, whether or not I am present at the actual appointment.

_____ (initials) At each visit that my minor child presents without my presence, I understand that I will receive a call to give a verbal consent for each visit, and that verbal consent will cover the tests, and treatment and also authorizes Logan Health to bill the insurance plan on file for those services.

_____ (initials) I understand that if I am not available by phone at the time of the visit, no treatment will be provided and the appointment will be cancelled.

_____ (initials) This authorization will remain in effect indefinitely; and will be reviewed annually, until the minor reaches legal consent age.

I have the right to revoke this Authorization at any time. Revocation must be in writing and presented to Health Information Management (Fax (406) 756-3523). Revocation will not apply to treatment that has already been received in response to this Authorization.

Parent/Guardian Signature _____ Date _____

Printed Name _____

Legal Representative _____ Relationship to Patient _____

Printed name _____

Witness Signature _____

LOGAN HEALTH
Kalispell, Montana

Consent for Treatment of Minor Child