Consent for Treatment of Minor Child



I, being the	parent/guardian of the following patient:	
Minor Patient Name		Date of Birth
(initials)	practitioner) of Logan Health, and the provide	al provider (physician, physician assistant, nurse er's staff, to perform necessary services for provider, whether or not I am present at the ,
(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 pho provided and the appointment will be cance	one at the time of the visit, no treatment will be lled.
(initials)	This authorization will remain in effect indef minor reaches legal consent age.	initely; and will be reviewed annually, until the
to Health		. Revocation must be in writing and presented 3). Revocation will not apply to treatment that tion.
Parent/G	uardian Signature	Date
Printed N	lame	
Legal Rep	oresentative	Relationship to Patient
Printed r	name	
Witness	Signature	

LOGAN HEALTH Kalispell, Montana

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