Consent for Non-Emergency Treatment of Minors

Patient: _____ DOB: _____

Address: _____ Phone Number: _____

Northern Medical Center strongly encourages that a parent or legal guardian accompany any minor children to their medical visits. In the event that a parent or guardian is unable to accompany his or her minor child to a medical visit, the parent or legal guardian should sign this Consent for Non-Emergent Treatment of Minor and send it to the health care provider or give to the minor child to present to the health care provider at the time of the medical appointment. In the event that a minor child presents for a non-emergent medical appointment without a parent or legal guardian or without a signed consent, the provider will obtain telephone consent before any care can be provided. Pursuant to this policy, medical treatment may be denied to an unaccompanied minor if provider is unable to obtain consent.

If there is a need to reach me during my child's appointment to discuss further care or treatment, or to confirm that I am the child's parent or legal guardian and that is my signature, I may be reached at the following phone numbers below: This form is only valid for the school year 8/28/2023-6/30/2024.

Acknowledgment/Authorization • I hereby acknowledge that I have received the NMC Notice of Privacy Practices. • I hereby acknowledge that I have received the NMC Patient Bill of Rights and understand I may request a copy. • I hereby acknowledge that I have received the info on Healthcare Proxy and Advanced Directives, If you have one of the following please indicate: Living Will, Advanced Directive • I consent to examination and treatment by the physicians and staff of NMC. • I consent to making my health care information available to other health care providers for treatment purposes. • I authorize and direct NMC to release to governmental agencies, insurance carriers and others who are financially liable for my medical care, any information necessary to process, or substantiate payment, for my insurance claims. • I hereby assign or transfer to NMC the payment of benefits to which I may be entitled from government agencies, insurance carriers or others who are financially liable for my medical care to cover the cost of care and treatment rendered to myself and my dependents. I request that payment of authorized benefits be made on my behalf and I understand, and agree that, regardless of my insurance status, I am ultimately responsible for charges not covered by policy or plan. • I agree that this authorization shall be valid until cancelled in writing or replaced with one of a later date. A photocopy of this assignment shall be considered as valid as the original. • Legal Name is defined as being the complete name on government issued identification or as attesting to on this registration form. • I have read all the information above and fully understand the terms thereof. • I certify that this information is true and correct to the best of my knowledge. I will notify NMC of any changes to the above information.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party Date

_____ _____

Print Name of Patient, Authorized Representative or Responsible Party Relationship DOB

Health History Form

Name: _____ DOB: _____

Health History: Please indicate all medical history, present and past diagnosis.

☐ Pacemaker ☐Joint Replacement ☐Arthritis ☐Fibromyalgia ☐ Scoliosis ☐Allergies ☐Asthma ☐High Blood Pressure ☐Low Blood Pressure ☐Diabetes ☐Heart Disease ☐Hepatitis/Liver Disease ☐Kidney Disorder ☐Thyroid Disease ☐Skin Disease ☐Bleeding Disorder ☐Blood Disease ☐Cancer/Tumor ☐Immune Disorder ☐HIV/AIDS ☐Multiple Sclerosis ☐Seizures/Epilepsy ☐Stroke ☐Mental Illness ☐Alcoholism ☐Substance Abuse ☐Other:_____

List of Medications: _____

Allergies to medications: _____

History of Surgery: ☐ Hernia Repair ☐Placement of ear tubes ☐Correction of bone fractures ☐Removal of skin lesions ☐ Splenectomy ☐ ☐Appendectomy ☐Biliary atresia

☐ Other: _____

Hospitalizations:

_____

_____

Parent/Guardian Signature_____

Date: _____