Bellevue Family Practice, P.C.

MINOR CONSENT FORM

Bellevue Family Practice cannot legally provide non-emergency care to a minor patient (under age 19) if a parent or legal guardian is not present unless a parent or legal guardian has granted permission. **The person you name must be 19 years of age or older.**

Consent Form

1. Complete all the information below and on page 2 of this form.

   Use a separate form for each child.

2. Return the form to Bellevue Family Practice.
3. This Consent for Medical Care is kept in the child's clinic chart. There needs to be a different form for each minor.

Services may include, but are not limited to, necessary medical treatment, including procedures, diagnostic examinations, including radiology and laboratory exams and the verification and/or administration of routine immunizations.

The parent/legal guardian will be attempted to be contacted should my minor child need more invasive diagnostic or surgical procedures before such care is initiated, but treatment will not be delayed.

Parental/Legal guardian consent is not legally required for minors who seek medical diagnosis and treatment for sexually transmitted diseases.

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I, (parent, legal guardian)_____ , cannot accompany my child, (child's name)_____, to Bellevue Family Practice. Therefore, I give permission to the following:

Name Date of Birth

_____

_____

_____

_____

☐ **I give permission to this person, if patient is at age to drive themselves, they can be seen without a guardian/parent present.**

☐ **I give permission for this person(s) to seek medical treatment for my child if attempts to contact me are unsuccessful. This permission does not include procedures requiring informed consent (such as any type of surgery).**

☐ **I give permission for this person(s) to seek medical treatment and consent for such treatment for my child without having to contact me. This permission includes procedures requiring informed consent (such as any type of surgery).**

Date _____

INSURED'S OR AUTHORIZATION PERSON'S SIGNATURE – I authorize payment of medical benefits to the undersigned physician or supplier for services

(Signature of parent or legal guardian)_____

I hereby certify that the signature is that of the patient's parent and/or legal guardian.

Address _____

Home Phone _____ Work Phone _____