

**COMMUNITY HEALTH CARE, INC. CONSENT FOR TREATMENT**

**MINOR UNDER THE AGE OF 18**

Patient­­­­­­­­­­­­­­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Chart #\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, allow the providers and employees of Community Health Care, Inc. to assess and treat the needs of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. This includes anything needed to diagnose the minor patient, any shots, or any treatments ordered by Community Health Care, Inc. providers. While giving care or while doing any lab procedures, the parent/guardian and/or CHC Staff may need to hold the child down. This could include: use of the papoose board, holding the child’s hands, upper body, head, and/or controlling leg movements.

I give permission to release the physical forms relating to my child’s checkup which may include mental health, and genetic testing, and drug abuse to my child’s school or daycare.

* I have been given a copy of the Patient Bill of Rights and Responsibilities and have been able to ask questions about it.
* I have been given a copy of the Notice of Privacy Practices. I can get extra copies of the notice when I ask for one.
* After your visit we give you a written health plan. We are not legally liable for the privacy of your information if you leave it or lose it.
* **I know that I need to update the consent form if changes need to be made. This consent is valid until I tell CHC to cancel it.**

**(Please continue on the backside)**

**Communication with Family & Others Involved in your Care**

Patient­­­­­­­­­­­­­­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Chart #\_\_\_\_\_\_\_\_\_\_\_

* Biological/Adoptive parents are allowed to bring their children to appointments and obtain medical information about their children. To make these processes easier please list both parents:

Biological/Adoptive Mother:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Biological/Adoptive Father:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand I should make every effort to accompany my child to appointments. If I am unable to come to an appointment, I give permission to Community Health Care Physicians as follows (**Choose one):**

* **I will allow the following names listed below to consent for my child’s treatment.**

**TYPE OF INFORMATION**

**NAME: RELATIONSHIP TO PATIENT:** All Scheduling/ Office Billing Papoose Prescriptions

Appointment Visit Board

(Dental/Lab)

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Specific Instructions or Limitations: \_\_\_\_\_\_\_

* I understand that my child may not be seen if he arrives at the clinic with a care giver who doesn’t meet the above chosen guidelines.
* I understand that a written permission note signed by me will always be acceptable as consent for any services included in the note.

**We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. In order for us to change your information please come in and fill out a new form.**

**I give Community Health Care my consent to send a reminder for me to come to my appointment by text message with the location, date and time of my appointment. CHC will keep sending reminders this way until I ask them to stop. Message and data rates may apply.**

* + **Yes Cell Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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(Patient’s Name Printed) (Signature of Patient/Legal Representative)

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(Date)