NW Metabolic Medicine
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nwmetabolic.com

CONSENT FOR TREATMENT OF MINOR

Please complete this form if your child will be examined or treated at Northwest Metabolic Medicine. Please note that it is our policy that all children under age 18 must have a parent / legal guardian present for the initial office visit, and minors 15 years old and younger must have an authorized adult present for all office visits.

Patient Name: _____ Date of Birth: _____

PARENTAL CONTACT INFORMATION

Parental contact information for questions regarding treatment of the minor child:

Parent's Name: _____
Cell Phone: _____
Daytime Phone: _____
Evening Phone: _____

Parent's Name: _____
Cell Phone: _____
Daytime Phone: _____
Evening Phone: _____

If we can discuss treatment with a non-custodial parent, enter their name here: _____
(Note that parents with joint legal custody will always have a right to receive information regarding care and treatment)

FINANCIAL RESPONSIBILITY & PAYMENT POLICIES

I have the legal right to authorize Northwest Metabolic Medicine, LLC to deliver treatment and services to my child. I understand that I am financially responsible for all medical expenses incurred by my child during these appointments. Northwest Metabolic Medicine collects fees at the time of service, so please ensure that the patient or patient's authorized representative is equipped to pay the designated amount at the time of the appointment.

_____ _____
Signature of Parent or Legal Guardian Date

COMPLETE THE FOLLOWING SECTION TO AUTHORIZE UNACCOMPANIED TREATMENT OR OTHER AUTHORIZED INDIVIVIDUAL

TIME PERIOD

I understand that I may revoke this consent at any time in writing. Please select one of the following options:

___ This authorization is valid as of the date signed and remains in effect until I revoke it in writing.
___ This authorization is valid from _____ until _____.
___ This authorization is valid for this day only: _____.

LIMITATIONS

If there are specific limitations on the kinds of medical services for which this authorization is given, please specify:

_____

AUTHORIZATION FOR UNACCOMPANIED TREATMENT (ages 16-18)

I have the legal right to authorize Northwest Metabolic Medicine, LLC to deliver treatment and services to my child. I request and authorize Northwest Metabolic Medicine, LLC personnel to deliver medical treatment and services, subject to the above specified conditions, to my child, named above, when they come into the office without me being present.

_____ _____
Signature of Parent or Legal Guardian Date

AUTHORIZED INDIVIDUAL OTHER THAN PARENT/GUARDIAN (all ages)

I have the legal right to authorize Northwest Metabolic Medicine, LLC to deliver treatment and services to my child. I request and authorize Northwest Metabolic Medicine, LLC personnel to deliver medical treatment and services, subject to the above specified conditions, to my child, named above, when they arrive at the office accompanied by the authorized named adult listed below.

_____ _____
Name of authorized adult Relationship to patient

_____ _____
Signature of Parent or Legal Guardian Date