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FAMILY TREE CLINIC

PARENT/GUARDIAN CONSENT FORM

Adolescents under age 18 must have a signed parent/guardian consent form on file to receive some general medical services. According to state law, parental consent is ***not*** required for pregnancy and contraceptive services, chemical abuse assessment and counseling, or diagnosis/testing and treatment of sexually transmitted infections. **** Note: A signed parent consent form lasts until the child turns 18, unless withdrawn. If the consent form is not returned, anyone under 18 will not be able to receive general medical services, however confidential reproductive health services are available by state law.****

Patient Name (preferred):_____ **Birth date**:_____/_____/_____

Legal name or name listed on insurance card:_____

This name will be listed in our electronic health record system and will be used for prescriptions, lab orders and billing purposes only. We will not call the patient by this name, but bills will be sent to your insurance company or mailing address with this name if there are outstanding balances.

My child has my permission to receive general medical services at Family Tree Clinic.

- ☐ If applicable, I give permission to bill my health insurance carrier or Medical Assistance for general medical services received. (This would also apply if you do not currently have insurance but get it later).
- ☐ I have received the notice of privacy practices stating I may have access to my child's general medical record but not to any confidential services provided, as stated in the Minnesota Statute 144.341-347.
- ☐ I understand I will be notified in case of emergency or need for follow up medical care.

_____ _____

Print parent/guardian name Print parent/guardian name

_____ _____ _____ _____

Date of birth Phone number Date of birth Phone number

_____ _____

Relationship to patient Relationship to patient

Please note any additional parents or guardians on the back of this form.

By my signature below, I confirm that I am the legal parent or guardian of the above named minor, that I have the legal authority to consent to medical care for the above named minor, and that I am allowing the above named minor to receive medical care at Family Tree Clinic.

_____ _____

Parent/guardian signature Today's date

IMPORTANT INSURANCE INFORMATION: PLEASE FILL IN ANY/ALL OPTIONS BELOW THAT APPLY TO YOUR CHILD.

- ☐ My child does not have medical insurance
- ☐ My child has Medical Assistance or MN Care. PMI and/or policy #:_____ Group #:_____
- ☐ My child has other insurance. Name of Insurance Company: _____
  Insurance Company Phone #:_____
  Insurance Company Address:_____
  Policy holder's name:_____ Policy holder's SS #:_____-_____-_____
  Member ID #:_____ Group #:_____

If you have any concerns regarding this consent form, please contact the Clinic Manager at (612)473-0800.