UPHS CLINIC | MINOR PATIENT CONSENT FORM

Patient Registration & Family/Guardian Information:

PATIENT NAME: _____
(Last, Jr., Sr., III) *(First)* *(Middle)*

PREFERRED NAME: _____ **PREVIOUS NAMES:** _____ **DATE OF BIRTH:** _____ **AGE:** _____

MAILING ADDRESS: _____ **GENDER IDENTITY:** _____ **GENDER ASSIGNED AT BIRTH:** _____

CITY / STATE / ZIP: _____ **MARITAL/PARTNER STATUS:** _____

PHONE: _____ **CELL:** _____ **EMAIL:** _____

EMPLOYER: _____ **MAY WE CALL AT WORK?** ☐ **YES** ☐ **NO** **WORK PHONE:** _____

RACE/ETHNICITY: *Asian/Pacific Islander Black Caucasian Hispanic American Indian Alaskan Native Declined Other:* _____

PREFERRED LANGUAGE: *English Other:* _____ **SOCIAL SECURITY #:** _____

EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____ **PHONE:** _____

1. PARENT, SPOUSE, NEAREST RELATIVE/GUARDIAN: _____ **RELATIONSHIP:** _____

MAILING ADDRESS: _____ **PHONE:** _____

EMPLOYER: _____ **WORK PHONE:** _____

2. PARENT, SPOUSE, NEAREST RELATIVE/GUARDIAN: _____ **RELATIONSHIP:** _____

MAILING ADDRESS: _____ **PHONE:** _____

EMPLOYER: _____ **WORK PHONE:** _____

Insurance Information: *(Staff will photocopy insurance cards)*

Can be left blank if copy of card attained

1st INSURANCE POLICY CO. (Primary): _____ **2nd INSURANCE POLICY CO. (Secondary):** _____

POLICY HOLDER NAME: _____ **POLICY HOLDER NAME:** _____

POLICY HOLDER SS#: _____ **POLICY HOLDER SS#:** _____

POLICY HOLDER DATE OF BIRTH: _____ **POLICY HOLDER DATE OF BIRTH:** _____

RELATIONSHIP TO PATIENT: _____ **RELATIONSHIP TO PATIENT:** _____

EMPLOYER: _____ **EMPLOYER:** _____

AGREEMENT FOR EXAMINATION AND/OR TREATMENT

I hereby agree and give consent for my minor child to be examined and treated by my physician. I understand I have the right to participate in decisions involving my child's health care. In the event my child may be harboring an infectious disease such as Hepatitis B or Human Immunodeficiency Virus (HIV) which could endanger the health of individuals accidentally exposed to my blood or bodily fluids, I do hereby voluntarily consent to such routine diagnostic procedures and care provided by UP Health System — Marquette as is deemed necessary by their physician (or his/her designee) or by the staff of the Clinic. I further understand that any test results will become part of my child's medical record, and as such its confidentiality is protected by Federal Law.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the release of any and all clinic medical records relevant to my minor child's examination and/or treatment, including laboratory and other interpretive reports and x-rays, to (a) the consulting and/or referring physician or agency or (b) the source(s) of continuing care, including but not limited to practitioners of UP Health System — Marquette medical staff, its facilities and clinics. I also authorize the release of these records for any payment or quality management related purpose to any (a) insurance carrier, (b) government agency or unit, or (c) any third party payor in any way involved in the payment for all or any part of my minor child's health care.

I hereby assign payment directly to the above named, UP Health System — Marquette, of authorized benefits to be made in my minor child's behalf not to exceed the balance due of the physician's regular charges. I understand that I am financially responsible to UP Health System — Marquette for charges not covered by this authorization under the provisions of the Federal Truth in Lending Law, 7169.

ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION

I authorize the healthcare provider to provide a copy of my of the medical record of my treatment, the discharge summary, and/or a summary or care record to my primary care physlcian(s), specialty care physician(s) and/or any health care provider(s) or facility(ies) identified in my plan of care to facilitate my minor child's treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases. information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing Information, and/or abortion-related Information. The summary of care record consists of Information from my minor child's medical record, including among other things, information concerning procedures and lab tests, my minor child's care plan, a list of my current and historical problems, and my minor child's current medication list. I understand that I may, by placing my request in writing to the healthcare provider, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my minor child's current treatment episode comes to an end.

OPTIONAL AUTHORIZATION TO RELEASE INFORMATION

I, _____, give UP Health System — Marquette Clinic, permission to communicate with the following people regarding my minor child's medical and/or financial information. This authorization is valid until such time as I provide UP Health System written revocation of it.

_____ **PLEASE CIRCLE:** *Financial* *Medical*

Name and Phone Number *Relationship to Patient*

_____ **PLEASE CIRCLE:** *Financial* *Medical*

Name and Phone Number *Relationship to Patient*

NOTICE OF PRIVACY PRACTICES ACKNOWELEDGEMENT *(One-time use)*

The notice of Privacy Practices for UP Health System — Marquette has been made available to me for my review. I understand that I may request a copy of the notice or obtain a copy from their website at ww.mgh.org at any time.

_____

Patient/Representative Signature *Date*

PATIENT RIGHTS AND RESPONSIBILITIES *(Offer annually)*

_____ **Patient's Rights and Responsibilities** have been made available to me and I have read and understand these Rights and Responsibilities.
Pt. Init.

_____ I have declined a copy of the **Patients Rights and Responsibilities** and am aware that they are available to me at mgh.org or on request in the future.
Pt. Init.

Many times Parents/Legal guardians find themselves unable to accompany their teen or young adult children to appointments. This section has been prepared for your convenience should you at some time be unable to accompany your teen or young adult child. This consent will give the designated individual authorize to consent to any and all treatment, immunizations , and/or procedures that may be needed at the office visit. This does not give authorization for blood draws or x-rays/imaging. **Minors 15 years old and younger MUST have an adult present** for all office visits or they will be asked to reschedule their appointment. If the patient is 15 years old and younger, theywill be able to be seen for their appointment with an adult present other than a Parent/Legal guardian ONLY if Parent/Legal guardian completes this consent form authorizing UP Health System Medical Group to provide treatment to their child.

CHILDREN 16 or 17 YEARS OLD: I HEREBY GRANT UP HEALTH SYSTEM MEDICAL GROUP CLINICS PERMISSION TO TREAT MY 16-17 YEAR OLD TEEN WHEN THEY ARRIVE AT THE OFFICE UNACCOMPANIED.

_____

Signature of Parent/Legal Guardian *Date*

CHILDREN 15 YEARS OLD OR YOUNGER: I HEREBY GRANT UP HEALTH SYSTEM MEDICAL GROUP PERMISSION TO TREAT MY CHILD WHEN THEY ARRIVE AT THE OFFICE ACCOMPANIED BY THE AUTHORIZED NAMED ADULT(S) LISTED BELOW.

_____

Name of Authorized Adult(s) *Relationship to Patient*

_____

Signature of Parent/Legal Guardian *Date*

It is the responsibility of the parent/guardian to notify the clinic if this authorization is rescinded prior to scheduled appointments within one year. UP Health System Medical Group clinics will not be responsible for confirming the authorized individual's continued consent if the situation changes. This consent with expire in one year from date signed.

I HAVE READ THIS CONSENT FORM AND I AM FULLY AWARE OF AND AGREE TO THE CONTENTS. THIS FORM IS FOR ONE YEAR FROM THE DATE OF THE MOST RECENT SIGNATURE.

X _____

Insured/Patient/Guardian/Guarantor *Dated*

X _____

Insured/Patient/Guardian/Guarantor *Dated*

X _____

Insured/Patient/Guardian/Guarantor *Dated*