Mercy
FAMILY CLINIC
NEW HAMPTON
A department of Mercy Medical Center–New Hampton

CONSENT TO TREAT MINOR CHILDREN

I, the undersigned person responsible for the undersigned patient, knowing that the patient suffers from a condition requiring medical care, do hereby voluntarily consent to such medical care by Mercy Family Clinic – New Hampton and Mercy Medical Center – New Hampton, encompassing routine diagnostic procedures and medical treatment by the provider, his/her assistants, or his/her designees as necessary in his/her judgment.

I am aware that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees have been made to me as to the results of treatment or examinations in the clinic. I do acknowledge and consent to examination and treatment of my child by the provider for Mercy Family Clinic – New Hampton.

I hereby assign Mercy Family Clinic – New Hampton and Mercy Medical Center- New Hampton all benefits otherwise payable to me under the medical expense provision on my insurance/Medicare benefits or so much thereof as may serve to satisfy my indebtedness to said clinic/hospital. I agree that, should the amount be insufficient to cover my entire medical expense, I will be responsible for payment of the difference and that if my disability were such that it is not covered by the policy contract, I will be responsible to said clinic/hospital for the payment of the entire medical bill. I understand that I will receive separate bills from the radiologists and other individual physicians for professional services performed.

I further authorize Mercy Family Clinic – New Hampton, members of the staff, administrators, nurses and officials of the said clinic to furnish my health insurance company or its representatives any information pertaining to the illness or injuries sustained by my child and the treatment thereof for which he/she received medical care at said clinic.

This authorization is effective from _____ to _____.
Today's Date One Year from Today

Child's Name: _____
(If you have more than one child, a separate form much be filled out for each child.)

Insurance _____ Policy # _____

Please send a copy of the insurance card or the original insurance card with your child to the appointment.

Parent or Legal Guardian (Print Name): _____

Signature of Parent or Legal Guardian: _____

<u>This additional information will assist in treatment if it can be furnished.</u>

Family address _____

Telephone: Father _____ home _____ work _____ cell

Mother _____ home _____ work _____ cell

Child's Birthdate _____ Last Tetanus _____

Allergies to drugs or foods _____ _____

Special Medications, Blood Type or Pertinent Information

_____

_____

This consent form should be taken with the child to Mercy Family Clinic-New Hampton when the child is taken for treatment.