



Children's Hospital of The King's Daughters Health System

UNACCOMPANIED MINOR AUTHORIZATION TO OBTAIN MEDICAL TREATMENT

Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service

The health of our patients is very important to us. We believe the parent/legal guardian is very important in promoting and maintaining the health of a minor. It is our recommendation that a parent/legal guardian or authorized adult be present during the deliver of healthcare services. However, we acknowledge minor are developing independence in meeting their own healthcare needs and that there are times when an authorized adult is unable to accompany the minor during the delivery of healthcare services. Therefore, we offer this authorization, which allows a minor, 14 years or older to obtain healthcare services when an authorized adult is unable to accompany a minor for the provision of healthcare services.

Until revoked by me, the parent/legal guardian identified below, verbally in person or in writing and delivered to the service area/practice personnel specified above, the minor established patient, 14 years of age or older, identified below has my permission to seek general medical, diagnostic, routine minor medical procedures and other related healthcare services without the presence of a parent/legal guardian. Services include but are not limited to:

- 1) examination, obtaining specimens, laboratory testing, diagnostic testing, medication administration and routine minor medical procedures;
2) testing of the minor's blood for HIV antibodies in accordance with state laws (Deemed Consent) which authorize health care providers to test patients when a health care provider is exposed to the body fluids of a patient.

I hereby authorize the physicians, employees, and other designated assistants affiliated with CHKD to treat the minor patient identified below, as deemed medically/therapeutically necessary and agree:

- 1) the minor patient, identified below, is authorized to sign on my behalf for the aforementioned medical care and services;
2) to guarantee payments including click on-payments and deductibles, in accordance with the regular terms and charges of the service area/practice, specified above, as consideration for services rendered to the minor patient under this authorization;
3) any portion of the bill not covered by insurance will be payable at the time of service unless other arrangements are made;
4) in the event of non-payment, the services area/practice, specified above, has the right to proceed against me or the responsible party(ies) without making any demands of, or taking any action or proceeding against each other as a prerequisite.
5) to pay all costs of collections, including collection agency fees up to thirty three and one-third percent (33-1/3%) of the amount owed.

PRINT First Name MI Last Name Relationship to child DOB

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Parent/Legal Guardian SIGNATURE Date

Parent/Legal Guardian SIGNATURE Date

Witness SIGNATURE Date

Notary Seal

Date: \_\_\_\_\_

Notary Signature: \_\_\_\_\_

A Notary is required if this form is not signed/witnessed in the presence of an employee of the service area/practice.