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## CONSENT TO TREAT AN UNACCOMPANIED MINOR

I \_\_\_\_\_ give permission to my child \_\_\_\_\_  
(Name of Legal Guardian) (Name of Child Age 16-17 years old)

DOB: \_\_\_\_\_ to attend ill visit appointments alone, without the presence of a legal guardian or authorized adult. I authorize treatment for my child in accordance with the policies of Bloomington Pediatrics. This includes providing a history of present illness, disclosure of protected health information, and responsibility for relaying any diagnosis, treatment plan, or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone and to be financially responsible for all copays, deductibles and/or coinsurance resulting from the visit. This authorization is effective on \_\_\_\_\_ and expires \_\_\_\_\_.

(Date Authorization is no longer valid)

(Today's Date)

### Child's Health Information

Currently prescribed or over-the-counter medications and dosages:

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_  
Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_  
Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_  
Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Allergies, illnesses or other comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Emergency Contact Information for Parents/Legal Guardians

Where/how can you be contacted in case of emergency? \_\_\_\_\_

Phone: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_

### Health Insurance Information

\*If no change since last accompanied visit, check here (\_\_\_) and skip to Signature.

If Insurance information has changed, please complete the following and plan to send the card with your child for scanning into their record.

Insurance Company: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ ID Number: \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_

Policy Holder Address (if different than patient): \_\_\_\_\_

**Parent or Legal Guardian's Signature:** \_\_\_\_\_

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