



PERMISSION TO TREAT A MINOR (16-18 Years)

I, _____, give permission for my child, _____, _____
Name of Guardian/Parent Name of Child age 16-18 years old Date of Birth

to attend his/her appointment(s) alone without my presence and authorize treatment for my child in accordance with the office policy. 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 and coinsurance. This authorization is effective on _____ and expires _____.
Today's Date Date Authorization is no longer valid, not to exceed 1 year

I have reviewed and signed all forms necessary for my child to visit Horizon Healthcare and have been given a copy of each. These forms include Assignment of Benefits, Acknowledgement of Legal Relationship, Consent for Medical Treatment, and Acknowledgement of Receipt of Privacy Notice. If my child is presenting for Behavioral Health Appointments, I have also read, reviewed, and signed the Informed Consent and Agreement for Psychotherapy Services, and the Behavioral Therapy Patient Appointment Agreement. These signed forms will remain effective until the expiration date above, or until changes have been made to any form by the facility for updating, in which case I will be required to sign the new form(s). My child will have my permission to sign required forms upon presenting for appointments.

My child's Health Information:

Current 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/Guardians:

Where/How can you be contacted in case of emergency?

Where: _____ Phone: _____

Comments: _____

Temporary Guardian Information: (PROOF OF LEGAL GUARDIANSHIP MUST BE PROVIDED)

Name: _____ Phone: _____

Address: _____

Health Insurance Information:

Insurance Company: _____ Policy Holder's Name: _____

Policy #: _____ Group Number: _____

Effective Date: _____ Co-pay: _____

Parent or Legal Guardian's Signature: _____ Date: _____

(Proof of Legal Guardianship must be provided)

Witness: _____ Date: _____