Her Health OBGYN

Consent to Treat Minor Child

I, _____, as parent or
NAME OF PARENT OR GUARDIAN

guardian for _____, do voluntarily
NAME OF PATIENT

consent to medical treatment by the provider, and her assistants, or her designee of Her Health OBGYN as necessary in her judgment. This consent includes routine, diagnostic procedures and medical treatment of conditions requiring medical care.

I am aware 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. I do acknowledge and consent to examination and treatment of my child by the provider(s) of Her Health OBGYN.

I assign Her Health OBGYN all benefits payable under the medical expense provision of my insurance. If my insurance benefits do not cover the entire expenses, I will be responsible to Her Health OBGYN for payment of the entire bill. I understand that I may receive separate bills from pathologists, labs or other entities for professional services provided.

I authorize Her Health OBGYN, members of it's staff, administrators and officials to furnish my health insurance company or it's representatives any information pertaining to the routine care, illness or injuries sustained by my child and the treatment for which she receives medical care.

This authorization is effective from _____ to _____

Parent or Legal Guardian (Print Name)_____

Relationship to Patient: ☐ Mother ☐ Father ☐ Legal Guardian

_____ _____
SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE

Telephone number where I can be reached_____