

# Fenway Health – Parent/Guardian Consent for Treatment of Minor

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ (A.M./P.M.)

I, \_\_\_\_\_ (print Parent/Guardian name here) am the parent/guardian of \_\_\_\_\_ (print Patient name here), currently a minor whose date of birth is \_\_\_\_/\_\_\_\_/\_\_\_\_. (mm / dd / yyyy)

I authorize Fenway Health to provide medical and/or behavioral health care to my child including, but not limited to, diagnostic examinations (including radiology and laboratory testing), tuberculosis screening, verification and/or administration of immunizations, any necessary medical treatment and behavioral health counseling. For surgical procedures, or more extensive medical care, attempts will be made to contact me before such care is initiated.

I understand that care may be provided without my consent when, in the opinion of the clinician, a delay in treatment would endanger the life, limb, or behavioral wellbeing of the patient. I also understand that if an injury/illness is determined to be life threatening that an ambulance will be called to take my child to the hospital and that the clinician will make every effort to contact me.

I understand that Fenway Health routinely performs confidential testing on adolescent patients as recommended by the American Academy of Pediatrics and the Centers for Disease Control. I understand that under Massachusetts Law, Fenway Health cannot discuss the results of these tests with a parent or guardian, even though such tests may appear on insurance or billing documents. I further understand that once my child reaches the age of maturity, my consent for treatment is no longer required and this consent form is no longer valid.

## Treatment, Payment and Data Agreement

- I authorize examination and treatment for this and all following medical or behavioral health visits.
- I understand I am personally responsible for all charges and deductibles. Financial assistance is available for those who qualify.
- I am personally responsible for providing accurate and current insurance information.
- I authorize a photocopy of this statement to serve as the original and the use of this signature on all insurance submissions.
- I authorize release of all information necessary to secure payments of benefits.
- I understand that Fenway Health may use data developed for and/or provided by clients to determine general characteristics of the communities it serves and that none of this information will in any way identify individual clients.

I acknowledge that I have read and understand this consent, and that any questions I had prior to signing could be answered by contacting Fenway Health Patient Services. I certify that the above information is true and correct. I have received a copy of Fenway's Notice of Privacy Practices (HIPAA) and Patient Rights and Responsibilities.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

General Information: Informed consent will be obtained from all patients accessing medical, behavioral health, and/or research services/activities. Informed consent is not merely a signed document. It is an ongoing process that considers patient needs and preferences, compliance with law and regulation, and patient education.

The patient and/or family, as appropriate, are given information about:

- The patient's condition;
- Proposed treatments, procedures, or research activities;
- Potential benefits and drawbacks of proposed treatments or procedures;
- Problems related to recuperation;
- Alternative treatment(s) or procedure(s);
- The physician or other practitioner primarily responsible for the patient's care;
- Others authorizing or performing procedures or treatments; and
- Any business relationships among individuals treating the patient, or between the organization and any other health facility.