

TREATMENT OF A MINOR

Policy:

This is Upper Cumberland Ear, Nose and Throat's written policy regarding scheduling and treating patients who are minors (i.e., all patients under the age of 18).

Parent/Guardian Authorization

1. The parent/guardian of all patients who are minors must sign an authorization form specifically identifying which other person(s) may accompany and approve treatment of their child(ren). Applicable for initial visits and updated annually or as circumstances warrant. The parent/guardian is the person who is financially responsible for any medical services.
2. The accompanying adult must present valid photo identification (e.g., driver's license) each time he/she accompanies a minor to their appointment. The photo identification will be scanned the first time it is presented and updated as necessary.
3. If the person accompanying the child(ren) is not among those authorized by the parent/guardian, then:
 - a. the front desk will obtain valid photo identification from the accompanying adult;
 - b. the clinical manager will attempt to call the parent/guardian and obtain verbal authorization for the accompanying adult to approve treatment for the child(ren);
 - c. if approved, the clinical manager will document the approval in the patient's chart (such approval must be verified/confirmed by a second employee);
 - d. if unable to talk to the parent/guardian, then either the patient must be rescheduled or must wait until verbal approval can be obtained.

PLEASE CHECK ONE OF THE OPTIONS BELOW

_____ I authorize the following person(s) to take my child for medical care and make any necessary decisions regarding my child's medical care.

(Full legal name of person authorized to take child for medical care)

(Date of birth of said person)

(Full legal name of person authorized to take child for medical care)

(Date of birth of said person)

(Full legal name of person authorized to take child for medical care)

(Date of birth of said person)

_____ I do not authorize anyone other than parent(s) or legal guardian(s) to take my child for medical care or make any decisions regarding my child's medical care.

(Name of Child)

(Child's Date of Birth)

(Signature of Parent or Legal Guardian)

(Today's Date)