0 2 2 7 5

Children's Hospital of The King's Daughters, Inc.
601 Children's Lane, Norfolk, VA 23507-1910

Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service

UNACCOMPANIED MINOR AUTHORIZATION TO OBTAIN MEDICAL OR MENTAL HEALTH TREATMENT

The health of our patients is very important to us. We believe the parent/legal guardian is very important in promoting and maintaining the health of a minor. It is our recommendation that a parent/legal guardian or authorized adult be present during the delivery of healthcare services. However, we acknowledge minors are developing independence in meeting their own healthcare needs and that there are times when an authorized adult is unable to accompany the minor during the delivery of healthcare services. Therefore, we offer this authorization, which allows a minor, 14 years or older to obtain healthcare services when an authorized adult is unable to accompany a minor for the provision of healthcare services at the following facility/practice and/or physician _____. This authorization is valid for the following time period _____ to _____unless revoked early by the parent, legal guardian, and/or physician.

Until revoked by me (or the physician), the parent/legal guardian identified below, verbally in person or in writing and delivered to the service area/practice personnel specified above, the minor established patient, 14 years of age or older, identified below has my permission to seek general medical, diagnostic, routine minor medical procedures and other related healthcare services within the facility/practice without the presence of a parent/legal guardian. Services include but are not limited to:

1) Examination, obtaining specimens, laboratory testing, diagnostic testing, medication administration and routine minor medical procedures; ***please remember any of these mentioned services may accrue additional cost. This form will not apply to services rendered outside of the facility/practice this form originated in.***
2) Testing of the minor's blood for HIV antibodies in accordance with state laws (Deemed Consent) which authorize heath care providers to test patients when a health care provider is exposed to the body fluids of a patient.

I hereby authorize the physicians, employees, and other designated assistants affiliated with CHKD to treat the minor patient identified below, as deemed medically/therapeutically necessary and agree:

1) the minor patient, identified below, to sign on my behalf for the aforementioned medical care and services;
2) the minor patient, identified below, is authorized to guarantee payments including click on-payments and deductibles, in accordance with the regular terms and charges of the service area/practice, specified above, as consideration for services rendered to the minor patient under this authorization;
3) any portion of the bill not covered by insurance will be payable at the time of service unless other arrangements are made;
4) in the event of non-payment, the services area/practice, specified above, has the right to proceed against me or the responsible party(ies) without making any demands of, or taking any action or proceeding against each other as a prerequisite;
5) to pay all costs of collections, including collection agency fees up to thirty three and one-third percent (33-1/3%) of the amount owed.

_____ _____
Patient's First Name M.I. Last Name Date

_____ _____
Parent/Legal Guardian SIGNATURE Date

_____ _____
Parent/Legal Guardian Print Name Relationship to Patient

_____ _____
Witness SIGNATURE Date

_____
Witness Print Name

Notary Seal

Date:_____

Notary:_____

Signature:_____

A Notary is required if this form is not signed/witnessed in the presence of an employee of the service area/practice.