Fenway Health Parent/Guardian Consent for Treatment of Minor

Patient Name: _____ Pronouns: _____ MRN: _____

Patient Date of Birth:_____ Today's Date:_____

I hereby authorize Fenway Health to provide medical, behavioral health, dental, and/or optometry care to my minor child or ward ("child"), including, but not limited to, diagnostic examinations (such as, but not limited to, x-rays, other radiology examinations, and laboratory testing), tuberculosis screening, verification and/or administration of immunizations, necessary or appropriate medical treatment, and behavioral health counseling.

I understand that this authorization is for treatment provided on the date of execution of this form.

For future treatment of my child, I hereby state as follows [*check and initial the applicable option for the applicable age*]:

For **minors age 16 or 17** (please initial applicable option):

-I hereby authorize Fenway Health to provide care for the child at future visits **without a parent/guardian or other authorized adult present, for routine medical, dental, optometry and/or behavioral care**. I am providing, below, contact information that will enable Fenway Health to reach me to respond to any questions a Fenway Health clinician may have during my child's visits; and I acknowledge that, at the discretion of the clinician, a conversation with me and/or a separate consent may be necessary before some treatments/procedures are administered. _____(Initial)

-I hereby authorize Fenway Health to provide care for the child at future visits if an adult whom I authorize is present with the child, as reflected on the attached Permission to Accompany Minor form. _____(Initial)

-I do not authorize Fenway Health to provide care for the child at future visits unless a parent or the child's guardian is present._____ (Initial)

For minors age 15 and under

-I hereby authorize Fenway Health to provide care for the child at future visits, **without a parent/guardian or other authorized adult present, but only for optometry and behavioral health care (including psychiatry), and NOT for other medical or dental care.** I am providing, below, contact information that will enable Fenway Health to reach me to respond to any questions a Fenway Health clinician may have during my child's visits; and I acknowledge that, at the discretion of the clinician, a conversation with me and/or a separate consent may be necessary before some treatments/procedures are administered. _____(Initial)

-I hereby authorize Fenway Health to provide care for the child at future visits if an adult whom I authorize is present with the child, as reflected on the attached Permission to Accompany Minor form. This includes optical and behavioral health care (including psychiatry), as well as medical and dental care. _____(Initial)

-I do not authorize Fenway Health to provide care for the child at future visits unless I, or my spouse, or the child's guardian is present._____ (Initial)

Regardless of my aforementioned choice, I understand that care may be provided to the child without my additional consent when, in the opinion of a Fenway Health clinician, a delay in treatment would endanger the life, limb, or behavioral well-being of the child. I also understand that if an injury or illness is determined to be life threatening, an ambulance will, if appropriate, be called to take my child to the hospital and that the Fenway Health clinician will make every reasonable effort to contact me.

I understand that, for surgical procedures and non-routine care deemed to involve a material risk of harm to the child, unless it is an emergency, I will be asked to sign a separate consent form for my child that describes the proposed care and its associated benefits, risks, and alternatives before such care is initiated.

I further 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.

Finally, I understand that this consent is valid until my child's 18th birthday unless I change or revoke the terms of the consent by contacting Fenway Health. I understand that once my child reaches the age of maturity (or is otherwise deemed capable of providing consent under Massachusetts law), my consent for the child's treatment is no longer required and this consent form is no longer valid.

- I hereby authorize examination and treatment of my child for this visit at Fenway Health, and I authorize examination and treatment for my child's subsequent medical and/or behavioral health visits at Fenway Health as provided herein.
- I understand that I am personally responsible for all charges and deductibles for my child's care at Fenway Health, and that financial assistance is available for such charges for those who apply for such financial assistance and qualify.
- I consent to Fenway Health sending me one or more messages per day related to my health care. I understand data usage costs may apply based on my mobile carrier plan.
- I authorize the use of ambient listening technology during my child's visits to assist in the completion of medical documentation. If at any time I do not consent to the use of this technology, I will inform my provider at the beginning of the visit.
- I am personally responsible for providing accurate and current health insurance information relating to my child's care.
- I authorize a photocopy of this consent form to serve as an original, and further authorize the use of the signature below on or for all insurance submissions in connection with my child's care by Fenway Health.
- I authorize release of all health and other information necessary to secure payment from me, my/my child's health insurer or other responsible party(ies) for my child's care by Fenway Health.
- I understand that Fenway Health may use data developed for and/or provided by patients, including my child, to determine general characteristics of the communities it serves and that none of this information will in any way identify individual patients.

I acknowledge that I have read and understand this consent, and that I had the opportunity to ask any questions I had regarding the consent by contacting Fenway Health Patient Services or Fenway Health clinicians. I certify that the above information is true and correct and that I consent to the care of my child as described herein. I also acknowledge that I have received a copy of Fenway's Notice of Privacy Practices (HIPAA) and Patient Rights and Responsibilities.

Signatures:

Parent/Guardian Signature: _____ Date:_____

Parent/Guardian Name (print): _____

Expiration date (if blank, this Consent will expire on the minor's 18th birthday): _____

Contact Information for Parent/Guardian:

Where/how can you be contacted in case of emergency or to respond to Fenway Health Inquiries?

Phone: _____

Email: _____

Comments:_____

_____

Temporary Guardian Information (if applicable):

Name: _____ Phone: _____

Address: _____