Glacier Ear, Nose & Throat Head and Neck Surgery
Glacier Hearing Services

This form must be completed prior to your arrival and faxed to the appropriate location provided at the bottom of the page

ACCOMPANIMENT, CONSENT, AND MEDICAL DECISION MAKING FOR A MINOR

I declare that I am the parent or legal guardian of _____.
Name of Minor

I confirm that the representative _____ is a personal representative
Name of Person Accompanying Minor

for all purposes relating to the minor child's or ward's protected health information. By my signature below, I do hereby consent to allow the representative to bring my dependent to GLACIER ENT for purposes of medical care and treatment.

If surgery is recommended, I hereby authorize the representative stated above to accompany and remain on the premises of the surgical center until the surgery and recovery is completed for my minor child.

I also acknowledge the risks of the recommended surgery and understand that the representative stated above may need to authorize medical treatment and make medical decisions for my minor child. This is to serve as an authorization for the above stated representative to assume medical decision making for this episode of care or surgery.

I also understand that I am financially responsible for any co-payments due at the time of service, and that I am responsible for furnishing GLACIER ENT with all insurance necessary to secure payment for visits.

I agree to furnish GLACIER ENT a copy of any court order, custody plan, power of attorney, letters of guardianship or similar document if requested.

I understand that GLACIER ENT is not obligated to examine or treat the child until all documentation it requires has been satisfied regarding authorization for examination and treatment and responsibility for payment.

_____
Parent/Legal Guardian Printed Name

_____ _____
Parent/Legal Guardian Signature Date

Glacier Ear Nose & Throat and Head and Neck Surgery Ph 406-752-8330 fax 406-752-8412

Glacier Hearing Services Ph 406-752-1014 fax 406-756-1379