NEW HEALTH
North End • Charlestown

CONSENT FOR TREATMENT OF MINOR CHILDREN

(if not accompanied by parent or legal guardian)

PATIENT'S NAME: _____ **DOB:** _____ **MRN#:** _____

I, _____, authorize North End Waterfront Health to administer routine and
(parent or legal guardian)
emergency medical care as deemed necessary by qualified medical personnel for the above-named patient. I hereby certify that I have read and fully understand this authorization.

The authorization is valid for:

- o Today's visit only
- o one year from the date below OR until revoked in writing by me.
- o Other (specify) _____

The child may be:

- o Accompanied by
- o Unaccompanied

Waiver of Liability for all clients at every visit

I understand I have a responsibility to ensure payment for the care and services my minor child receives from North End Waterfront Health. I understand that I will be responsible for the payment of any and all services rendered today, whether or not I have verified my care benefits.

_____
Print name of parent/legal guardian

_____ _____
Signature of parent/legal guardian Date