PHYSICIANS' CLINIC
of Iowa, P.C.

AUTHORIZATION TO TREAT A MINOR

Minor's Name: _____ Minor's Date of Birth: _____

Name of Parent or Legal Guardian: _____ Primary Contact Number: _____

MINORS:

A minor is defined under Iowa law as an individual under 18 years of age, not married, and not self-supporting. Written authorization or permission from a parent or legal guardian is required to treat a minor if the parent or legal guardian cannot be present for the appointment. Generally, the authorization must be completed **in person** by the parent or legal guardian. If the written authorization is not received, a consent via telephone for current date of service will be accepted with appropriate verification. If appropriate authorization is not received, the appointment is rescheduled until the appropriate permission is obtained and documented or parent/guardian is in attendance. Note, however, the attending physician/provider may elect not to treat without parent/guardian present.

In addition to emergency situations, the following are exceptions to obtaining the parent or legal guardian's permission:

1. Minors may consent to treatment for birth control and reproductive issues, for the prevention, diagnosis or treatment of a sexually transmitted infection, testing and treatment for HIV/AIDs, or drug or alcohol dependency. A minor who is 12 or older may consent to tobacco cessation counseling services. A victim of sexual abuse or unlawful sexual conduct may also obtain immediate or shot-term medical services or mental health services. Generally, though there are some exceptions, the parent or legal guardian may not be notified by the physician unless permission from the minor is obtained and documented in the patient's record.

2. Emancipated minors may consent to their own treatment, demonstrated with an emancipation order.

As the parent of legal guardian for the patient, I will allow the health care team(s) at Physicians' Clinic of Iowa to give the following treatment(s) to my child:

☐ Allergy / Audiology
☐ Ear, Nose & Throat
☐ Family Medicine
☐ General Surgery
☐ Hematology & Oncology
☐ Imaging
☐ Lab
☐ Neurology & Sleep Medicine
☐ Orthopaedics/Spine/Therapies
☐ Osteoporosis & Bone Health
☐ Pediatrics
☐ Physical Medicine & Rehabilitation
☐ Plastic & Reconstructive Surgery
☐ Podiatry
☐ Rheumatology
☐ Urology
☐ Vascular Surgery
☐ Walk-in Care

Other treatment(s) (if applicable): _____

I understand that:

- This consent applies only to the treatments checked/marked/noted above. I agree to reimburse for any services rendered, if applicable.
- This consent applies only when I am not present with my child to give consent to treatment. If I am with my child, I will decide whether to give consent to suggested treatment.
- This consent for treatment is valid for **one year** unless a shorter time frame is listed below

  Start Date: _____ End Date: _____ (Telephone authorization is acceptable for one date only.)

- I may revoke (take back) this consent, at any time, by telling PCI in writing. It is my responsibility to update PCI in case of any material changes.

☐ Person Authorized to Accompany Minor and Consent to treatment/services (print name and relationship) : _____

☐ Minor may present self for care (age 14 and older), with the exception of immunizations/vaccinations.

This is to certify that I, the undersigned, consent to, and authorize the performance of all treatments and services, including the administration of anesthetics, which may be deemed necessary in the judgement of the attending PCI provider.

_____ _____
Signature of Parent or Legal Guardian (Legal Guardian must provide documentation) Date

Note: Telephone authorization is acceptable for one date only. Verbal permission is given by parent or legal guardian for child's visit on _____

Phone authorization First Staff witness (print and sign): _____/_____

Phone authorization Second Staff witness (print and sign): _____/_____