Authorization and Consent for Treatment of a Minor

In presenting my daughter for diagnosis and treatment

Name:_________________________________for___________________________ (Circle one: **Mother/Father/Legal Guardian**) **Patient Name**

Of___________years of age, I hereby voluntarily consent to health care services today by the providers at OB/GYN Associates of Des Moines, PLC.

I acknowledge that I am responsible for all charges in connection with the care and treatment rendered today.

Parent/Legal Guardian Name: ____

Date of Birth_______________________Social Security #:_____________________ Phone (Home/Cell):

_______________________________________Work Phone: ___________________ Address:_____

____ City/State/Zip:

(Please note: We send lab specimens to Mercy unless you request otherwise.) I request and authorize health care services by the provider as he/she deems advisable and in my daughter's best interest. This may include routine diagnostic, radiology, and laboratory procedures as well as medication administration and drug screening during pregnancy.

I hereby authorize the release of any information acquired in the course of the examination or treatment for the processing of an insurance claim. I also request that payment of authorized Medicare benefits and any other insurance benefits be made to OB/GYN Associates of Des Moines, PLC for any services provided to her by them.

I agree to pay OB/GYN Associates of Des Moines, PLC for any co-insurance, co- payments, deductibles, or other amount not paid for by the insurance. Failure to do so may result in collection action or denial of future treatment.

By signing this form, I also agree that OB/GYN Associates of Des Moines, PLC can request and use her prescription medication history for other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Signature:_____________________________________**Date:**

Please email the completed form to transcription@obgyndm.com.