intuition wellness center
LEARN. GROW. THRIVE.

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Consent for Medical Services of a Minor Unattended by Parent(s)/Legal Guardian(s)

Client Name: ______________________ ***Date of Birth:*** ______________

*I/we hereby consent for the above-named minor child to receive routine medical care from Kathryn Sage, NMD, of Intuition Wellness Center, PLLC without the presence of a parent/guardian and/or without the presence of a parent/guardian but at the direction of the following third-party:**

Third-Party Name* (skip if not applicable): ______________________

Relationship to Client: *Stepparent* *Guardian* *Grandparent* *Aunt/Uncle*

Other: ______________________

____
Street Address *City* *Sate* *Zip*

Phone: ______________ *Email:* ______________

Each third party is required to have a separate Intuition Wellness Authorization for Release of Information on file.

Parent/Legal Guardian Emergency Contact (required): *I/we can be reached during the appointment at the phone number(s) listed on page two.*

Routine Medical Care: *For purposes of this Consent, routine medical care shall include, without limitation:*

- *health screenings, check-ups, wellness examinations, sports physicals and patient education/counseling intended to prevent illness, disease, or other health problems;*
- *all services deemed medically appropriate by Intuition Wellness and provided in response to a complaint or condition identified by the client and/or their parent/legal guardian or duly authorized third party; and,*
- *all services deemed medically appropriate by Intuition Wellness and intended to identify or evaluate a new condition or illness, to monitor an already known condition or illness, or to treat said condition or illness.*

Routine Medical Care Exclusions: *Following are examples of exclusions from routine medical care:*

- *Routine genital exam over the age of four*
- *Non-routine lab work*

Additional Medical Information: *Following is all information that I/we want Intuition Wellness to know about my/our child (i.e., allergies, medications, diagnoses by other health care providers, general concerns or exclusions, etc.):*

Duration of Authorization/Expiration: *This Consent is valid until the earlier of the occurrence of: (a) written revocation received by Intuition Wellness; (b) termination of treatment; (c) or the following date: __________ / _________ / __________.*

Month Day Year

I UNDERSTAND THAT MY TYPED NAME BELOW IN THE SIGNATURE LINE REPRESENTS MY ELECTRONIC SIGNATURE.

Both parent(s)/legal guardian(s) are required to sign this form.

______________________________	______________________________
Parent/Guardian Printed Name	*Parent/Guardian Printed Name*
______________________________	______________________________
Signature of Parent/Guardian	*Signature of Parent/Guardian*
______________________________	______________________________
Date/Time of Signature	*Date/Time of Signature*
______________________________	______________________________
Emergency Phone Number (required)	*Emergency Phone Number (required)*