

## 2017-18 Providence Mt Hood Meadows Mountain Clinic Consent to Treat

Providence Health & Services – Oregon dba Providence Hood River Memorial Hospital Mountain Clinic (“Providence”) is a medical first aid clinic located at Mt. Hood Meadows Ski Resort that provides emergency response and immediate care. For serious injuries or illnesses, clinic staff will stabilize and transfer patients to an appropriate medical facility.

In case of injury or illness requiring medical intervention, every effort will be made to notify parent/guardian. In the event that this is not possible, completing and signing the below form authorizes Providence to provide medical treatment to your child. Please note, that in the case of an emergency situation, parental consent is not needed to provide emergency medical treatment to a minor child.

STUDENT/PARTICIPANT INFORMATION			
Last name	First name	Date of birth	Gender
Home address		Apartment or building number	
City	State	Zip code	
Home phone	Student/participant cell phone	Group organizer/group name	Organizer phone
PARENT/GUARDIAN INFORMATION			
Last name	First name	Date of birth	Relationship to student/participant
Parent phone (Best contact number)	Parent alternate phone	Parent email address	
EMERGENCY CONTACT INFORMATION			
Name	Phone	Relationship to student/participant	
MEDICAL INFORMATION			
Medical provider name/phone	Dentist name/phone	Date of last tetanus shot	
Allergies (Including medication allergies)	Current medications		
Health history (Chronic or existing diseases or medical problems – i.e. asthma or diabetes)			
FINANCIAL INFORMATION			
Insurance company name	Insurance subscriber ID number	Group/plan number	
Subscriber name	Relationship to patient	Subscriber date of birth	

Please initial below (All boxes must be initialed and form signed for non-emergent services to be performed):

- \_\_\_\_\_ I consent for my minor child to receive health care services provided by Providence and I affirm that I have the right to consent as the parent or legal guardian of the minor child listed below.
- \_\_\_\_\_ I authorize Providence and their staff to communicate with my minor child’s healthcare providers about healthcare services rendered by Providence.
- \_\_\_\_\_ I accept financial responsibility for all treatment provided. The balance is due 30 days from the billing date. If I need financial assistance or wish to establish a payment plan I can contact a Providence financial representative.
- \_\_\_\_\_ I authorize Providence to bill my minor child’s health insurance provider for healthcare services rendered at Providence.  
 Medicare and Medicaid enrollees: I request payment of authorized Medicare or Medicaid benefits be made on my minor child’s behalf for any services furnished to my minor child by Providence.
- \_\_\_\_\_ I am aware that Providence has teaching facilities and that a student may be involved in my care

Parent/guardian name: \_\_\_\_\_ Parent/guardian signature \_\_\_\_\_

Student/participant name: \_\_\_\_\_ Date: \_\_\_\_\_