Northwest Natural Health®
A Specialty Care Clinic

CONSENT TO TREAT A MINOR

This completed and signed authorization is required for each child.

I (we) the undersigned parent(s) or legal guardian of: _____, a minor, born on _____/____/_____, do hereby authorize and consent to any diagnostic and/or therapeutic naturopathic services, which is deemed advisable by a licensed provider of naturopathic services or be rendered under the general or special supervision of any licensed provider of naturopathic services by any member of the medical staff at Northwest Natural Health® Specialty Care Clinic.

It is understood that this authorization is given in advance of any specific examination, medical diagnosis, treatment or care being rendered, and is given to provide authority and power to render care which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

I accept responsibility for all charges related to any medical consultation and/or treatment rendered by reason of this authorization.

This authorization is effective until _____, 20_____. If no time period is designated, this authorization shall terminate one year from today's date.

List any restrictions or specify authorized treatment:

_____

_____

This consent was signed by: _____ _____
Print Name of Parent(s) or Legal Guardian — Relationship

_____ _____
Must be signed by Parent or Legal Guardian — Date

Phone number(s) where Parents can be reached:

Father: (___ _)_____ Home/Cell (_ ___)_____ Work

Mother: (___ __)_____ Home/Cell (_ ___)_____ Work

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(**Supplemental)**