Gage County Medical Clinic
A Beatrice Community Hospital and Health Center Physician Clinic
1101 North 10th St.
Beatrice, NE 68310

CONSENT TO MEDICAL TREATMENT FOR MINOR CHILD

I, _____, certify that I am the parent/legal guardian of __ _____, a minor ("Child"), and that I am authorized to provide informed consent for any medical treatment provided to my Child.

I understand the nature of the treatment or procedures, and I acknowledge that no guarantees have been made to me or my child as to the results of treatment or examination performed at the Clinic.

Furthermore, I acknowledge that I am financially responsible for any and all medical examinations and treatments provided to my Child at the Clinic. I hereby assign and authorize payment directly to the Clinic any and all third party payor benefits otherwise payable to me. I hereby agree that the Clinic may issue a receipt for any such payment and that this receipt shall be a conclusive acknowledgement by me that I have received insurance benefits from the insurance company(ies) in the sum specified in such receipt, and agree that such payment shall discharge the insurance company(ies) of any and all obligations under the policy(ies) to the extent of such payment and for that purpose. I expressly authorize the Clinic to furnish the insurance company(ies) with any information desired concerning said medical care and treatment. I understand that I am financially responsible to the Clinic for charges not covered by this assignment and further agree to guarantee prompt payment in full of any balance due.

I further authorize the following can present child for medical treatment.

_____ _____

_____ _____

_____ _____

I further authorize that _____(name of minor child) **can present self for treatment with the exception of:** (please state the exceptions or state "none". _____.

A photocopy of this document shall be considered as valid as the original.

Dated this _____day of _____, _____

_____
Signature of Parent or Legal Guardian