



CARE OF MINOR OR ADULT WITH A GUARDIAN

Attention Parents and Guardians: Please read and complete this page carefully.

Patient Information	Name: _____ DOB: _____															
Parent/Guardian Information	Name (First, MI, Last) _____ Address: _____ City, State, Zip: _____ Phone Number: _____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work Phone Number: _____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Email Address: _____															
READ	Registration and Treatment of a Minor or Adult with a Guardian: <ol style="list-style-type: none"> 1. I understand that Open Door Health Center requires that I complete registration forms prior to providing care for the patient listed above. 2. I understand that Open Door Health Center requires a parent be present with the above patient for their first appointment. 3. I understand that optimal treatment is provided to the patient when I accompany him or her. My presence also facilitates legal consent for care. 4. In the event I am unable to be at a future appointment with the patient listed above, I may authorize a Designated Decision Maker to be present and provide consent for care for him or her. I must indicate in the Emergency Contact area of this form if the individuals listed are to be considered Designated Decision Makers. I am aware that protected health information may be shared with the designated decision maker to facilitate informed decision making. 5. A provider may provide care to an unaccompanied minor if a valid consent to treat is on file and a Designated Decision Maker as "SELF" is listed below or documented in a care plan that a minor child may attend future visits alone. If a previously agreed upon care plan does not exist, a parent or guardian may consent either verbally (e.g. by telephone) or in writing (e.g. fax). 															
Designated Decision Maker/Emergency Contact <i>Indicate if each individual is a DDM (Dedicated Decision Maker) and/or EC (Emergency Contact)</i>	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 20%; text-align: center;">DDM</th> <th style="width: 20%; text-align: center;">EC</th> </tr> </thead> <tbody> <tr> <td>Name: _____ Phone: _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Name: _____ Phone: _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Name: _____ Phone: _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Name: _____ Phone: _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>		DDM	EC	Name: _____ Phone: _____	<input type="checkbox"/>	<input type="checkbox"/>	Name: _____ Phone: _____	<input type="checkbox"/>	<input type="checkbox"/>	Name: _____ Phone: _____	<input type="checkbox"/>	<input type="checkbox"/>	Name: _____ Phone: _____	<input type="checkbox"/>	<input type="checkbox"/>
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Unaccompanied Minor or Person with Guardian	If I or my Designated Decision Maker (as listed above) is unable to be or remain present at the time care is to be provided to the patient listed above, I understand that Open Door Health Center may not provide treatment without documented consent obtained verbally. Open Door Health Center may contact me at the phone numbers listed above so that care may be provided to the patient listed above if I am not present. _____ Initial															
Exceptions to Parental Consent as specified by Minnesota Law	Minnesota Statute (§144.341-144.347) allows exceptions to obtaining parental consent. I understand that if I would like a copy of these exceptions, I may ask Open Door Health Center staff to provide a copy.															
Signature	I understand that my signature acknowledging Open Door Health Center policy regarding care of the patient listed above will last for <u>one year</u>. I understand that I may at any time, withdraw my acknowledgement or consent through written notice. If I do so, it will not affect actions already taken by Open Door Health Center.															
	Parent/Guardian Signature _____															
	Date _____															

For office use and verification only: Scan copy of photo ID of Designated Decision Maker.