2018-19 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: _____