2012-2013

CONSENT TO TREATMENT

FOR USE AT ANY LICENSED HOSPITAL AND/OR EMERGENCY CENTER

STUDENT ______________________________ BIRTHDATE ______________

AGE __________ MEDICATIONS ______________________________

ALLERGIES ______________________________

SIGNIFICANT MEDICAL HISTORY ______________________________

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PARENT/GUARDIAN'S NAME ______________________________ PHONE # ______________

PERSON RESPONSIBLE FOR BILL ______________________________

RELATIONSHIP TO STUDENT ______________________________ BIRTHDATE ______________

PHONE # ______________ ADDRESS ______________________________

EMPLOYER ______________________________ EMPLOYER PHONE # ______________

Student is not currently covered by any insurance policy.

Student is currently covered by the following insurance policy:
(Please make a copy (front/back) of insurance card and forward to Highland Academy.

INSURANCE COMPANY ______________________________ GROUP # ______________

INSURANCE GROUP ADDRESS ______________________________

EMERGENCY CONTACT **OTHER THAN PARENT OR GUARDIAN**

NAME ______________________________ PHONE # ______________
Home Cell Work

NAME ______________________________ PHONE # ______________
Home Cell Work

I UNDERSTAND TERMS ARE CASH FOR SERVICES RENDERED AT THE NEAREST APPROPRIATE HOSPITAL AND/OR MEDICAL CENTER. IN URGENT AND/OR EMERGENCY SITUATIONS, BILLING FOR SERVICES MAY BE NECESSARY. I UNDERSTAND THAT IN TREATING MY DEPENDENT, GIVEN HOSPITAL AND/OR MEDICAL CENTER IS ACTING IN GOOD FAITH AND WILL BE EXPECTING FULL PAYMENT OF THE BILL AFTER I RECEIVE A STATEMENT. I AM GIVING PERMISSION FOR TREATMENT, AND ASSUME FULL RESPONSIBILITY FOR THE BILL, WHETHER INSURANCE PAYS ONLY A PORTION, OR NONE AT ALL. IN THE EVENT MY ACCOUNT BECOMES PAST DUE, I AGREE TO PAY MONTHLY BILLING FEES AND BE RESPONSIBLE FOR ALL ADDITIONAL CHARGES SHOULD COLLECTION PROCEEDINGS BECOME NECESSARY. I UNDERSTAND THIS FORM MUST BE SIGNED, DATED AND RETURNED PRIOR TO ANY MEDICAL TREATMENT TO BE RENDERED BY THE PHYSICIANS AT GIVEN HOSPITAL AND/OR MEDICAL CENTER.

I, the undersigned guardian of, ____________________________(student), a minor, do hereby consent to any x-ray, examination, anesthetic, or surgical diagnosis or treatment, and hospital service that may be rendered to said minor under the general or specific instructions of any physician the school may call, whether such diagnosis or treatment is rendered at the office of said physician, at a licensed hospital, or at the school.

It is further understood that this consent is given in advance of any specific diagnosis or treatment which might be required and is given to authorize the school or the physician to exercise his best judgment as the requirement of such diagnosis of treatment.

This consent shall remain in continuous effect until revoked in writing or until said minor is removed by the parent or guardian from the care of Highland Academy. We hereby authorize any hospital or physician, or any other person who has attended or examined said minor to furnish the school's insurance company or its representative any and all information with respect to all illness, medical history consultation, prescriptions or treatment, and copies of all hospital or medical records. A photocopy of this authorization shall be considered as effective and valid as the original.

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Parent/Guardian Signature   *Date*

*****Witness must be a non-family member*****

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Witness Signature   *Date*