

MINOR CONSENT TO TREAT, LEGAL AUTHORITY ATTESTATION, AND INDEMNIFICATION AGREEMENT

Minor Patient Information

Full Name: _____ Date of Birth: _____

Adult Presenting With Minor

Full Legal Name: _____ Date of Birth: _____

Government Issued Photo ID Type: Driver's License Passport ID Number: _____

Full Address: _____

Phone Number: _____ Email: _____

Relationship to Minor (check one)

- Biological parent Adoptive parent Court-appointed legal guardian Court-appointed custodian
 Person with valid written medical power of attorney Other (explain): _____

Legal Authority Representation and Attestation

By signing below, I represent, warrant, and affirm under penalty of perjury under the laws of the Commonwealth of Pennsylvania that:

1. I represent and warrant that I have full legal authority to consent to any and all healthcare services, evaluations, treatments, procedures, consultations, and related clinical services provided within the lawful scope of practice of Altheda Medical Center and its licensed providers on behalf of the above-named minor.
2. My authority is not restricted, limited, suspended, or subject to any court order, custody limitation, or pending legal dispute that would prohibit or restrict my ability to authorize treatment.
3. No other parent, guardian, custodian, or court-appointed decision-maker possesses sole, exclusive, or superior medical decision-making authority that would limit, override, or invalidate my authority to consent to treatment on behalf of the minor.
4. I understand that Altheda Medical Center is relying on my representations in providing care to this minor.
5. I acknowledge that Altheda Medical Center is entitled to rely upon my representations without independent investigation.
6. I understand that if I am not the biological or adoptive parent, I may be required to provide court documentation, guardianship paperwork, or written medical authorization. I agree to provide such documentation upon request.
7. I agree to immediately notify Altheda Medical Center if my legal authority changes in any way.

Scope of Consent

I hereby authorize Altheda Medical Center and its physicians, certified registered nurse practitioners, physician assistants, behavioral health providers, contractors, employees, affiliates, successors, and assigns to provide any and all healthcare services within the lawful scope of practice of its licensed providers, as determined in the professional judgment of the treating clinician. This authorization includes, without limitation:

- Evaluation, examination, and diagnosis
- Preventive and wellness services
- Acute and chronic care management
- Behavioral and mental health services
- Medication prescribing, adjustment, and monitoring
- Laboratory testing and diagnostic procedures
- Referrals and care coordination
- In-person and remote services utilizing evolving healthcare technologies
- Any additional services within the lawful scope of practice of Altheda providers now or in the future

I acknowledge that healthcare services offered by Altheda Medical Center may expand, evolve, or change over time, and this consent applies to all lawful services provided within the professional scope of practice of its clinicians.

Telehealth Consent



Phone: (412) 875-5275 | Fax: (412) 679-7051
info@altheda.com

If services are provided via telehealth, I consent to the use of electronic communication technologies and confirm that I am legally authorized to consent to such services for the minor. I acknowledge that the provider may document the identity of all individuals present during telehealth encounters.

Custody Dispute Acknowledgment

I understand that Altheda Medical Center does not adjudicate custody disputes and is entitled to rely upon the representations made by the adult presenting with the minor. I acknowledge that if conflicting custody claims arise after care has been provided, Altheda Medical Center shall not be responsible for resolving such disputes and shall not be liable for care provided in reasonable reliance upon my representations.

Indemnification and Hold Harmless

I agree to indemnify, defend, and hold harmless Altheda Medical Center, its physicians, nurse practitioners, physician assistants, employees, contractors, affiliates, and agents from and against any and all claims, damages, losses, liabilities, costs, and expenses, including attorney's fees, whether arising in contract, tort, statute, or otherwise, arising from:

- Any misrepresentation of my legal authority
- Any dispute regarding custody or medical decision-making authority
- Any failure on my part to disclose restrictions on my authority

Financial Responsibility and Insurance Authorization

I acknowledge and agree that I am financially responsible for all charges incurred for healthcare services provided to the above-named minor, regardless of insurance coverage status.

If insurance information is provided, I authorize Altheda Medical Center to bill the applicable insurance carrier on behalf of the minor. I understand that insurance coverage is not a guarantee of payment and that I remain personally responsible for any charges not covered, denied, reduced, or otherwise unpaid by the insurer, including but not limited to deductibles, copayments, coinsurance, non-covered services, or services determined not medically necessary by the insurer.

If I am not the primary insurance subscriber, I represent and warrant that I have authority to provide the insurance information and to authorize submission of claims related to the minor. In the event of a custody dispute, coverage dispute, or retroactive denial of insurance benefits, I agree that such disputes do not relieve me of financial responsibility for services rendered in reliance upon my authorization. I further agree to indemnify and hold harmless Altheda Medical Center from any financial loss resulting from misrepresentation of insurance information or legal authority.

False Representation Warning

I understand that knowingly providing false information regarding guardianship or legal authority may constitute fraud and may subject me to civil or criminal penalties.

Duration of Authorization

This authorization shall remain valid and in effect for all services rendered by Altheda Medical Center unless and until:

1. The minor reaches the age of majority under applicable law;
2. The undersigned's legal authority to consent is modified, restricted, or terminated; or
3. The undersigned provides written revocation of this authorization to Altheda Medical Center.

The undersigned agrees to immediately notify Altheda Medical Center in writing of any change in custody status, guardianship, court order, or legal authority affecting medical decision-making rights for the minor. Altheda Medical Center is entitled to rely upon this authorization unless and until written notice of revocation or legal limitation is received. Altheda Medical Center shall have no obligation to independently verify ongoing custody status absent written notice.

Signature

I declare under penalty of perjury that the foregoing statements are true and correct.

Signature of Adult: _____ Printed Name: _____ Date: _____