



TRI-HEALTH

Family wellness center

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Consent for Treatment of Minor

The State of Florida has enacted a new law that imposes additional obligations on health care providers when obtaining consent to treat a minor child. This form seeks to comply with our obligations under this new law, including obtaining a written consent to prescribe, where medically indicated, medicinal drugs needed by the minor child identified below. The new law also states that written consent must be obtained from a parent who has legal custody of the minor child or is the legal guardian of the minor child.

Minor Patients Information

First Name: _____

Last Name: _____

Date of Birth: _____

Insurance Plan: _____

Street Address: _____

Insurance ID#: _____

City/State: _____

Zip Code: _____

Parent/Legal Guardian's Information

First Name: _____

Last Name: _____

Date of Birth: _____

Relationship: _____

Driver's License #: _____

Phone #: _____

- I attest that I am the parent/legal guardian for the minor child listed above.
- I understand that my insurance or existing payment method will be billed for the services rendered to the minor listed above.
- I understand this authorization is valid until the 18th birthday of the patient, OR upon written revocation.
- I understand this form must be completed in order for TriHealth Family Wellness Center, and/or any of its medical professionals to treat my above minor.
- I give TriHealth Family Wellness Center, LLC, its medical professionals, and employees, consent to provide, solicit and arrange for health care services, and prescribe medicinal drugs, when necessary, to the minor child named below.

By signing below, I represent that I am either a parent with legal custody of the legal guardian of the minor child named below.

Parent /Legal Guardian Signature _____ Date _____