



North End Waterfront Health

332 Hanover Street
Boston, MA 02113
617 643 8000
northendwaterfronthealth.org

NEW
HEALTH

CONSENT FOR TREATMENT OF MINOR CHILDREN
(if not accompanied by parent or legal guardian)

PATIENT'S NAME: _____ **DOB:** _____ **MRN#:** _____

I, _____, authorize North End Waterfront Health to administer routine and
(parent or legal guardian)
emergency medical care as deemed necessary by qualified medical personnel for the above named patient. I
hereby certify that I have read and fully understand this authorization.

The authorization is valid for:

- Today's visit only
- One year from the date below unless revoked in writing by me
- Other (specify) _____

The child may be:

- Accompanied by _____
- Unaccompanied

Waiver of Liability for all clients at every visit

I understand I have a responsibility to ensure payment for the care and services my minor child receives from North End Waterfront Health. I understand that I will be responsible for the payment of any and all services rendered today, whether or not I have verified my care benefits.

Print name of parent/legal guardian

Signature of parent/legal guardian

Date

