Glacier Ear, Nose & Throat Head and Neck Surgery

Glacier Hearing Services

This form must be completed prior to your arrival and faxed to the appropriate location provided at the bottom of the page

CONSENT FOR CARE AND TREATMENT OF A MINOR

YOU MUST ATTACH A PHOTOCOPY OF THE PARENT OR GUARDIAN'S DRIVER'S LICENSE TO THIS FORM.

I declare that I am the parent or legal guardian of	. I confirm
that the representative	Name of Minor is a personal representative for all
purposes relating to the minor child's or ward's protected hereby consent to allow the representative to bring my de medical care and treatment.	
I also understand that I am financially responsible for any I am responsible for furnishing GLACIER ENT with all insvisits.	
I agree to furnish GLACIER ENT a copy of any court orde of guardianship or similar document if requested.	r, custody plan, power of attorney, letters
I understand that GLACIER ENT is not obligated to exam documentation it requires has been satisfied regarding au responsibility for payment.	
Parent/Legal Guardian Printed Name	
Parent/Legal Guardian Signature	
Date	
Glacier Ear Nose & Throat and Head and Neck Surger Glacier Hearing Services	y Ph 406-752-8330 fax 406-752-8412 Ph 406-752-1014 fax 406-756-1379