Livingston HealthCare
Billings Clinic Affiliate

Ranger Clinic Parental/Legal Guardianship Consent Form

PARENTAL CONSENT FOR RANGER CLINIC

Ranger Clinic provides behavioral health services from a Clinical Psychologist and medical services from a Nurse Practitioner. I give permission for my child to be seen by a provider at Ranger Clinic as indicated above. I understand Ranger Clinic will inform me of any emergency visits my child may have by phoning my contact telephone number. I give permission for Ranger Clinic to request and/or share my child's records as needed.

My signature indicates I have received a copy of the Notice of Privacy Practices and Patient Rights (available at http://www.livingstonhealthcare.org/pdfs/PrivacyNotice.pdf).

Student Name (Print): ______________________________ ☐ **I decline Ranger Clinic services for my child at this time**

X ____ ________________
Signature of Parent/Guardian **Date**

HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

I have read and understand the release of health information included with this form. My signature indicates my consent to release medical information as specified.

X ____ ________________
Signature of Parent/Guardian **Date**

INSURANCE INFORMATION

Is your child covered by Medicaid Insurance?

No Yes:Medicaid ID # ________________________

Which Plan?
Healthy Montana Kids (HMK)
Healthy Montana Kids Plus (HMK plus)
Other: ______________________________

Considered for financial assistance?

Does your child have other insurance?

No Yes:
Insurance Carrier: ______________________________
Subscriber: ______________________________
Policy Number: ______________________________
Group Number: ______________________________
Insurance Billing Address: ______________________________
____

Please complete back page.

Please review the following information and authorization for treatment if/when you cannot be present at the time of treatment. Sign if you wish to authorize Ranger Clinic to provide treatment for your child.

I (we) have the legal right to preauthorize this facility to deliver treatment to my (our) dependent during the 20_____/20_____ academic year. I (we) request and authorize Ranger Clinic and its personnel to deliver the care to my (our) dependent listed below. We understand that we will be notified by telephone (at the contact number listed below) if my(our) dependent is being seen under an emergency situation.

Identify any limitations in the kind of services for which this authorization is given.

Limitations:____

____

If the nature of the medical care is not routine, please note we will try to contact you at the telephone numbers listed below.

PATIENT INFORMATION	***PARENT/GUARDIAN INFORMATION***

PATIENT INFORMATION

Patient's Last Name: ________________________________

Patient's First Name: ________________________________

Date of Birth: __________/__________/____________
Month *Day* *Year*

Age _______________

Patient's Address:___________________________________

____

_____________________ _____ _______________
City *State* *Zip Code*

Does the patient have a behavioral health therapist?

Name: ____

Telephone: ____

PARENT/GUARDIAN INFORMATION

Mother

Last Name: __________________First Name: _______________

Home Tel: ________________ Work Tel: ___________________

Phone: ____

Address: ____

Father

Last Name: _________________ First Name: _______________

Home Tel: ________________ Work Tel: ___________________

Phone:____

Address:____

Legal Guardian, If Applicable

Last Name: __________________First Name: _____________

Relationship of legal guardian to student

Grandparent __ Aunt __ Uncle Other:______________

Phone: ________________ Work Phone: ________________

Address:____

Additional Emergency Contact

Name: ____

Relationship to Student: _____________________________

Home Tel: _________________ Work Tel: _________________

Phone: ____