FCMH FRANKLIN COUNTY MEMORIAL HOSPITAL & RURAL HEALTH CLINICS
Caring for those you care about
1406 Q Street Franklin, NE 68939
Franklin – Red Cloud
308-425-6221
800-753-2479

MINOR CONSENT TO TREATMENT

Patient Name : _____ Date of Birth: _____

I consent to the care provided by the health care professionals associated with Franklin County Memorial Hospital and Franklin County Medical Hospital Medical Clinics, including diagnostic procedures, examinations, medical and minor surgical treatment or clinical services recommended by such professionals and performed by them, their assistants, or other designees.

I understand that this Consent to Treatment will be valid and remain in effect, unless and until revoked, in writing. I have reviewed this Consent to Treatment, understand its contents, and have had an opportunity to ask any questions I might have. I voluntarily sign below.

FINANCIAL AGREEMENT: I agree to be financially responsible and to pay for the services rendered to the patient accordance with the regular rates and terms of Franklin County Memorial Hospital and Franklin County Memorial Hospital Medical Clinics.

TREATMENT OF MINOR: If the above-named patient is a minor, my signature below as the parent/guardian of the minor authorizes Franklin County Memorial Hospital and Franklin County Memorial Hospital Medical Clinics to provide medical/dental/vision and/or emergency treatment to the patient. I understand that this authorization is given in advance of any specific diagnosis or treatment. My Signature below is intended to provide ongoing consent to treatment, and I intended this Consent to Treatment to be in force when the patient is accompanied to Franklin County Memorial Hospital and Franklin County Memorial Hospital Medical Clinics by family members (grandparents, aunts/uncles, cousins, adult sibling) and the following designated unrelated adults:

Consent to accompany minor to Franklin County Memorial Hospital and Franklin County Memorial Hospital Medical Clinics, list below:

_____ _____

_____ _____

_____ _____

_____

Printed Name

_____ _____ _____

Signature Relationship to patient Date

Updated July, 2022