Tus neeg mob lub npe *Patient name*			
MHN *MHN*	Hnub yug *DOB*	Muaj tsawg xyoo *Age*	Poj niam los txiv neej *Gender*

Tso Cai Kho Rau Cov Menyuam Uas Tsis Tau Muaj Hnub Nyoog (Siv Ib Zaug Xwb)

Kev Tso Cai

Nplooj 1 ntawm 2

Consent – Treatment of Minors – Limited (One Time Use)

Page 1 of 2

Qhov yuav kom ua raws li txoj kev cai lij choj hauv Wisconsin, Marshfield Clinic Health System xav kom tau niam txiv (tsis yog niam tshiab txiv tshiab/niam qhuav txiv qhuav) los sis ib tug neeg saib xyuas uas tau kev tso cai los ntawm kev cai lij choj (tus neeg saib xyuas uas tsev hais plaub xaiv) tuaj nrog cov menyuam uas tsis tau muaj hnub nyoog (17 xyoo rov hauv) thaum lub sij hawm lawv tuaj kho mob/kho hniav. Puas hlwb yog thaum uas niam txiv los sis tus neeg saib xyuas uas tau kev tso cai los ntawm kev cai lij choj tuaj tsis tau nrog nws tus menyuam uas tsis tau muaj hnub nyoog ntawd mus kho mob/hniav/puas hlwb, tus niam txiv los sis tus neeg saib xyuas uas tau kev tso cai los ntawm kev cai lij choj yuav tsum tau kos npe rau Daim Ntawv Tso Cai Kho Mob Rau Cov Menyuam Uas Tsis Tau Muaj Hnub Nyoog – Siv Ib Zaug Xwb.
To comply with Wisconsin law, Marshfield Clinic Health System requires that a parent (not step-parent/foster parent) or legal guardian (guardian appointed by a court) accompany any minor children (17 years old or younger) to their medical/dental/mental health appointments. In the event that a parent or legal guardian is unable to accompany his or her minor child to a medical/dental/mental health treatment appointment, the parent or legal guardian must sign this Consent – Treatment of Minors – Limited (One Time Use) form.

Niam txiv los sis tus neeg saib xyuas uas tau
kev tso cai los ntawm kev cai lij choj lub npe _____
Name of parent or legal guardian

Tus neeg mob lub npe _____
Patient name

Tus neeg tso cai _____ Txheeb ze li cas rau tus me nyuam _____
Appointee (person authorized to consent) *Relationship to child*

☐ Kuv pom zoo txog rau kev saib xyuas thiab kho mob rau kuv tus menyuam txog nws li kev teem caij kho mob / kho hniav / kho mob hlwb hauv Marshfield Clinic Health System thiab lawv cov chaw koom tes:
I consent to care and treatment for my child related to his/her medical/dental/mental health treatment appointment at Marshfield Clinic Health System and affiliates:

rau thaum lub *(hnub tim – hli/hnub tim/xyoo)* _____ /_____ /_____
on (date – month/day/year)

yog rau *(teem sij hawm kho dab tsi – cov kev pab kho mob tshwj xeeb uas tau kev pom zoo lawm/cov txheej txheem kho mob/cov kev soj ntsuam seb mob li cas/kev txhaj tshuaj)* _____
for (reason for appointment – specify approved care/procedures/tests/immunizations)

_____

nrog rau *(tus neeg muab kev pab kho mob lub npe)* _____
with (health care provider name)

☐ Kuv tus menyuam uas paub tab, hnub nyoog muaj _____ (tsis yau dua 16 xyoo) yuav tuaj kuaj mob/hniav/puas hlwb tau nws ib leeg rau lub sij hawm uas teem tseg rau nws.
My mature child, age (#) (not less than 16) can attend this medical/dental/mental health treatment appointment alone.

Tso Cai Kho Rau Cov Menyuam Uas Tsis Tau Muaj Hnub Nyoog (Siv Ib Zaug Xwb)

Kev Tso Cai (Txuas mus)

Tus neeg mob lub npe *Patient name*	MHN *MHN*	Hnub yug *DOB*	Muaj tsawg xyoo *Age*	Poj niam los sis txiv neej *Gender*

Yog hais tias yuav hu tuaj cuag kom tau kuv rau lub sij hawm uas teem tseg rau kuv tus menyuam es yuav tham txog kev kho mob mus ntxiv, yuav hu tau rau kuv ntawm cov xov tooj hauv qab no:
If there is a need to reach me during my child's appointment to discuss further care or treatment, I may be reached at the following phone numbers:

Hauv tsev (_____) _____ – _____ Tom hauj lwm (_____) _____ – _____
Home *Work*

Ntawm cev (_____) _____ – _____ Lwm tus xov tooj(_____) _____ – _____
Cell *Other*

Kuv pom zoo mus ntxiv yuav them tej nuj nqes rau Marshfield Clinic Health System tus neeg muab kev pab kho mob rau cov nqi kho mob yog hais tias kuv lub qhov chaw them nqi kho mob tsis them rau cov nuj nqes no.
I further agree to reimburse Marshfield Clinic Health System health care provider for the cost of rendering these services to the extent that my insurance does not pay for these services.

Tus menyuam niam thiab txiv/tus neeg saib xyuas uas tau kev tso cai los ntawm kev cai lij choj kos npe
Child's parent or legal guardian signature

(Kev sib txeeb rau tus neeg mob)
(Relationship to patient)

Sau tus menyuam niam thiab txiv/tus neeg saib xyuas uas tau kev tso cai los ntawm kev cai lij choj lub npe
Print child's parent or legal guardian name

/ /
Hnub tim (hli/hnub tim/xyoo)
Signature date (month/day/year)

Tus menyuam niam thiab txiv/tus neeg saib xyuas uas tau kev tso cai los ntawm kev cai lij choj qhov chaw nyob
Child's parent or legal guardian address

Tus me nyuam niam txiv/tus neeg saib xyuas tus xov tooj
Child's parent/legal guardian phone number

Xa daim ntawv thov uas teb meej mus rau: Health Information Management, Marshfield Clinic Health System, 2727 Plaza Drive, Wausau, WI 54403 Fax: 715-847-3069 E-mail: mclhim.consents@marshfieldclinic.org
Send completed form to: Health Information Management, Marshfield Clinic Health System, 2727 Plaza Drive, Wausau, WI 54403 Fax: 715-847-3069 E-mail: mclhim.consents@marshfieldclinic.org

