

Ranger Clinic Parental/Legal Guardianship Consent Form

PARENTAL CONSENT FOR RANGER CLINIC

Ranger Clinic is an outreach of Livingston HealthCare located at Park High School. It serves primarily SGMS and PHS students who can attend appointments independently. Ranger Clinic offers both medical and behavioral health services. By signing this form, I give permission for my child to be seen by a provider at Ranger Clinic at any appointments I schedule through the current school year. I agree that if my child needs emergency care, Ranger Clinic staff will inform me as soon as possible by phoning my contact number.

I also understand that my child's health information may be shared consistent with Livingston HealthCare's Privacy Practices to facilitate treatment, payment, and health operations. You can view the Notice of Privacy Practices on our website available at <https://www.livingstonhealthcare.org/Patients-Visitors/HIPAA-Notice.aspx>

X _____ Date: _____
Parent/guardian signature

Student Name (Print): _____ **Date of birth:** _____

- I consent to medical services for my child at Ranger Clinic
 I consent to behavioral health services for my child at Ranger Clinic
 I decline all Ranger Clinic services for my child at this time

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?

The services provided at Ranger Clinic will have a charge(s). LHC will bill your insurance, and any co-pays, coinsurances, or deductibles will be your responsibility.

LHC wants to help you and your child receive needed care. Please don't hesitate to reach out. Financial assistance is available through LHC and would help pay for your child's other healthcare services at LHC. Medicaid and Market Place health plans would help pay for your child's care at LHC and other health care facilities. We are happy to help you sign up.

Please call 406.823.6414 or email PreAccess@livhc.org to discuss more financial resource options, make a payment, or update your insurance information.

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

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: _____