Consent to Treatment – Health Insurance Information

New Orleans Adventist Academy

Consent to Treatment

We, the undersigned parents, or guardians, of (student's name) _____ a minor, do hereby consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital service that may be rendered to said minor under the general or special instructions of (physician's name) _____ or any physician the school may call, whether such diagnosis or treatment is rendered at the office of said physician or at a licensed hospital. It is understood that reasonable effort will be made to contact the doctor listed above before any other physician is called.

It is further understood that this consent is given in advance of any specific diagnosis or treatment, which might be required and is given to authorize New Orleans Adventist Academy or the physician to exercise their best judgment as to the requirements of such diagnosis or treatment. This consent shall remain in continuous effect until revoked in writing and delivered to the physician named above or to the school entrusted with the custody of said minor.

The above named student ☐ is ☐ is not covered by health insurance.

Present Health Insurance Company: _____ Policy Number: _____

Physician's Address: _____

Physician's Phone #: _____

Signatures

Parent / Guardian Printed Name _____ Date _____

Parent / Guardian Signature _____

Registration Information for Emergency Department Benefits

Patient's Name _____ Patient's Birth Date _____

Patient's Address _____

Patient's Phone # _____ Sex _____ Religion _____

Allergies _____

Patient's Under the Age of (18) Eighteen

Parent Guardian's Name _____ Patient's Birth Date _____

Parent / Guardian Address _____

Parent / Guardian Phone # _____ Employer _____ Employer Address _____