TEXAS TECH MEDICAL CENTER - EL PASO
AMBULATORY CLINIC

POLICY AND PROCEDURE

Title: **Consent For Treatment For Minors**

Date Issued: 3/97 Reviewed 06/01, 04/04 Policy #: 8.10

POLICY:

The Purpose of this TTMC-EP Policy and Procedure is to establish guidelines for Consent For Treatment For Minors.

SCOPE:

This policy cover's all TTMC-EP clinics.

PROCEDURE:

1. Patients being registered at TTMC-EP will be asked to sign a "consent for treatment" form or have the form signed on their behalf by a legally authorized representative. (Texas Tech University Health Sciences Center Form No. 12.1).

    a. All general consents for treatment will be witnessed by personnel in the Central Registration Department, or respective clinic site, dated and placed on the left hand side of the Medical Record.

2. The Texas Family Code provides that a minor may consent to his own medical treatment if the minor:

    a. is on active duty with the armed services of the United States,

    b. is 16 years of age and resides separate and apart from his parents, managing conservator, or guardian with or without parental consent and regardless of the duration of such residence and manages his own financial affairs,

    c. consents to diagnosis and treatment of any infectious, contagious, or communicable disease that the law requires licensed physicians and dentists to report to a local health officer or the Texas Department of Health, including all sexually transmitted diseases,

    d. is unmarried and pregnant and consents to hospital, medical, or surgical treatment related to her pregnancy, other than abortion,

    e. consents to examination and treatment for chemical addiction, chemical dependency, or any other condition directly related to chemical use,

    f. consents to counseling or counseling in conjunction with treatment by a physician, psychologist, counselor, or social worker if the treatment and/or counseling is for

sexual abuse, physical abuse, suicide prevention, or chemical addiction, dependency, or abuse.

Note: The minor's written statement explaining the grounds on which the minor has capacity to consent to his own care is adequate for the hospital, physicians, dentists, hospitals or other medical facility.

3. Mothers who have given birth to a child but are under the age of 18, may sign for that child's treatment.

    a. If the mother is a minor, she may sign for her own treatment.

4. Obtaining a Consent for Minors:

    a. Generally, a minor does not have the capacity to consent to medical treatment for himself and any consent which he may attempt to give is invalid. (*Exception: Item's in #2 above)

    b. Under Texas law, a "Minor" is defined as "a person under 18 years of age who is not and has not been married or who has not had his disabilities of minority removed for general purposes.

    c. When a child under the age of 18 is registered for treatment, the "consent for Treatment" may be signed by:

        - Natural Mother,
        - Father as to whom child is legitimate,
        - Adoptive mother or father,
        - Parent who is appointed managing conservator of child,
        - Other person, not a parent, who is appointed managing conservator of child,
        - Possessory conservator may only consent in an emergency or if specifically granted that power by the court.

    d. If one of the persons listed above cannot be contacted and has not indicated otherwise, the health care provider should look to (order not important):

        - A grandparent,
        - Adult (18 years of age or older) brother or sister,
        - Adult (18 years of age or older) aunt or uncle,
        - Educational institution in which minor is enrolled that has received written authorization to consent from persons having power to consent,
        - Any court having jurisdiction over the child,
        - Any adult who has care and control of the minor and has written authorization to consent from the person with the power to consent,
        - Any adult responsible for the care and control of a minor under the jurisdiction of a juvenile court or committed by such court to the care of any agency of the state or county, if the adult has a reasonable belief that the minor is in need of immediate medical treatment. Such as person shall not be liable for the examination and treatment of the minor except for his own acts of negligence. The Texas Youth Commission may consent to the medical treatment of any minor

committed to it when the person having the power to consent has been contacted and actual notice to the contrary has not been given.

e. If consent is obtained from one of these "alternate" individuals or entities, the consents must:

1. be in writing;
2. be signed by the person giving consent;
3. contain the name of the parent or legal guardian;
4. reflect the name of the person giving consent and his relation to the minor, and;
5. contain a statement of the nature of treatment and when it will begin.

5. Consent for Immunizations:

a. Any of the following may consent to immunization of a minor if a parent, managing conservator, or guardian of the minor child cannot be contacted and has not refused consent to immunizations:

- A grandparent
- Adult (18 years of age or older) brother or sister,
- Adult (18 years of age or older) aunt or uncle,
- Step-parent
- Another adult who has care and control of the minor and has written authorization to consent from person having the power to consent,
- Any adult responsible for the care and control of a minor under the jurisdiction of juvenile court or by commitment by a juvenile court to the care of a state or county agency, if the adult reasonably believes the minor needs immunizations or
- An adult having care and control of the minor as the primary care giver, if the adult is granted the right to consent to immunization of the minor by order of a district court.

Note: "Cannot be contacted" means the location of the person is unknown and a reasonable attempt has been made by the persons listed above to locate and communicate with the person now having power to consent, and not more than 90 days have passed since the effort was made: or the person who may consent refuses to make a decision regarding consent or delegate, and the person does not expressly deny authority to the grandparent, adult brother or sister, or another person listed above.
All efforts to contact the legal guardian will be thoroughly documented as to number of attempts and exact steps taken.

PATIENT LABEL (NAME, DOB, MRN)

Texas Tech University Health Sciences Center
Ambulatory Clinics

CONSENT TO TREATMENT:

I voluntarily consent to receive medical and health care services provided by TTUHSC physicians, employees and such associates, assistants, and other health care providers, as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations, and treatment. I understand that TTUHSC is a teaching institution and I agree to be a part of the teaching programs. I acknowledge that no warranty or guarantee has been made to me as to result or cure.

I understand that this consent to treatment will be valid and remain in effect as long as I attend the TTUHSC Ambulatory Clinics unless revoked by me in writing with such written notice provided to each clinic attended by me.

CONSENT TO DISCLOSURE OF PROTECTED HEALTH INFORMATION: Your protected health information pertains to your diagnosis and/or treatment at TTUHSC, including but not limited to information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs or communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), laboratory test results, medical history, treatment progress or any other such related information.

By signing this form, you consent to TTUHSC's use and/or disclosure of protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. Our Notice of Privacy Practices provides information about how TTUHSC and its workforce may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law.

> **RELEASE FROM LIABILITY:** I release and agree to hold harmless TTUHSC and its agents, representatives, and employees from any and all liability associated with the release of confidential patient information in accordance with this authorization. I understand TTUHSC cannot be responsible for use or redisclosure of information by third parties.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: In consideration for receiving medical or health care services, I hereby assign my right, title, and interest in all insurance, Medicare/Medicaid, or other third-party payer benefits for medical or health care services otherwise payable to me to TTUHSC physicians and/or Medical Practice Income Plan. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third-party payer, up to the total amount of my medical and heath care charges, to TTUHSC physicians and/or Medical Practice Income Plan. I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid, is correct.

I agree to pay all charges for medical and health care services not covered by or which exceed the amount estimated to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third-party payer and agree to make payment as requested by TTUHSC.

I certify that this form has been fully explained to me, that I have read it or had it read to me*, and that I understand its contents.

ADVANCE DIRECTIVE:
I have signed an Advance Directive. ____ YES ____ NO;

If yes, is it still in effect? ____YES _____ NO; I have provided a signed copy to TTUHSC. _____ YES _____ NO

Notice of Privacy Practices:
I have received a paper copy of TTUHSC's Notice of Privacy Practices. _____
(Patient's Initials)

_____	_____	_____
Date	Time	Patient/Other legally authorized person
_____	_____	_____
Witness *	Print Name	Print name and relationship to patient