Women's Care Center of Columbus, Inc.

Temporary Guardian Authorization

I, ____, as parent or guardian for
NAME OR PARENT OR GUARDIAN
the patient,____, do authorize as
NAME OF PATIENT
my child's temporary guardian, ______________________________________,
NAME OF TEMPORARY GUARDIAN
to consent to medical treatment by the provider, and her assistants, or her designee of Women's Care Center of Columbus, Inc. as necessary in her judgment. This consent includes routine, diagnostic procedures and medical treatment of conditions requiring medical care. This consent is effective for the period of time from (date)__________________ to (date)__________________.

I am aware my temporary guardian will be required to provide a photo ID on arrival to Women's Care Center of Columbus, Inc.

I assign Women's Care Center of Columbus, Inc. all benefits payable under the medical expense provision of my insurance. If my insurance benefits do not cover the entire expenses, I will be responsible for payment of the difference. If my benefits to do not cover services provided, I will be responsible to Women's Care Center of Columbus, Inc. for the payment of the entire bill. I understand that I may receive separate bills from pathologists, labs or other entities for professional services provided.

I authorize Women's Care Center of Columbus, Inc., members of its staff, administrators, nurses and officials to furnish my health insurance company or its representatives any information pertaining to the routine care, illness or injuries sustained by my child and the treatment thereof for which she received medical care.

Parent or Legal Guardian (Print Name)____________________________________

Relationship to Patient: ☐ Mother ☐ Father ☐ Legal Guardian

Signature of Parent or Legal Guardian______________________________________

Telephone number where I can be reached:____________________Date_______