Emergency Medical Care Consent

Client Name: _____ DOB: _____ Record No: _____

If Child: Mother's Name: _____ Phone: _____

Father's Name: _____ Phone: _____

Legal Guardian: _____ Phone: _____

Special Medical Needs (allergies, medication, medical conditions, etc.): _____

_____

_____

_____

Local Hospital Preference: _____

Primary Care Physician: _____

Insurance Carrier: _____ Policy #: _____

Emergency Contacts:

_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone

I, the undersigned, hereby authorize the staff of Thrive Counseling Services PLLC to produce emergency medical care for me/my child if deemed necessary. This shall include emergency First Aid by authorized personnel of the program. Should further medical treatment be necessary, I understand the County Rescue Unit will be called and will transport me/my child to the nearest hospital. I farther understand that I will assume financial responsibility for medical care, including payment of physician, emergency service, ambulance service and medical facility fees.

_____	_____	_____
Client/Legal Guardian Signature	Name Printed	Date
_____	_____	_____
Therapist Signature	Name Printed	Date