Robert D. Plambeck, MD, PC
1001 S 70th St, Suite 220
Lincoln, NE 68510

Office Use Only
Patient Name_____
Patient # _____
Recorded in PM & EHR by _____

Consent for Treatment of a Minor

The age of majority for the State of Nebraska is 19-years-old. Treatment for services to anyone under the age of 19 must have the consent of a parent or legal guardian.

I am the parent or guardian of _____, date of birth: _____, a minor. I am legally authorized to provide informed consent for her. If I am unable to accompany my daughter to a medical appointment, I want Robert D. Plambeck, MD, PC to:

Choose only ONE of the options below:

1. **Call me** for any and all needed consents. My cell phone number is: _____
2. **The practice can provide the medical services I initial below** without obtaining further consent from me. I understand that if I initial a medical service, no further consent from me will be needed for the medical service. Please indicate your consent by initialing as appropriate:

   _____Routine office visits, including annual pelvic exams, pap smears, breast exams

   _____Laboratory tests, including blood test or cultures

   _____Office procedures, including colposcopies and ultrasounds

   _____Prescriptions/injections, including birth control, antibiotics, etc

   _____Prenatal care/obstetrical care

3. **The practice can provide all medical services required or requested by the minor with her consent**. No consent from me for those medical services will be needed. A confidential relationship between the minor and the practice will be created. No information about these medical services will be provided to me by the clinic or its provider unless authorized by the minor.

I understand and agree that 1. I am financially responsible for all medical services provided by the practice to the minor; 2. any consent I provide in this document will be effective until the minor is age 19, is married, is emancipated, or I provide written notice to the practice to revoke my consent; and 3. a minor may consent to some medical care under state law, such as treatment of STDs, and can control access to and the release of her medical records for that care apart from any consent in this document.

Patient Name: _____ Date of Birth:_____
Print Name **MM/DD/YYYY**

Parent/Guardian Name: _____
Relationship:_____
Print Name

Parent/Guardian Signature_____
Date:_____

Rev. 10/20/2022