♥ WELCOME ♥

WELCOME!

It is our pleasure to welcome your family to *The Children's Clinic of Klamath!*

We are very excited that you have chosen us, and can't wait to get-to-know you and and your health goals... *"Growing up Together"*, **we can offer you the best care possible for your child/children!**

PRIMARY CARE MEDICAL HOME

We want you to feel welcome, cared for, and respected **at every appointment...** just like you do in your own home! That's why we make it easy and comfortable for you to get the care you need, in the way that works best for your family.
As your Medical Home, we will:

- Listen to you and answer your questions.
- Connect you to care, information, and services to keep you healthy.
- Encourage you to have an active role in your own health and to help and support you in any way we can!

- In return, we ask that you get involved in your care, team up with us to meet your health goals, and let us know when you have questions or concerns.

Immunizations are an essential part of well child care. CCK follows the national immunization guidelines set forth by the American Academy of Pediatrics, and the American Academy of Family Physicians.

APPOINTMENTS

We are open Monday through Friday from 8:00am to 5:00pm, with our first appointment starting at 8:30am.

We do our best to accommodate same-day appointments. Please call early as openings tend to fill up quickly.

Well Care
Please schedule check-ups 2 to 4 months in advance so you can reserve a time that works best with your schedule.

Cancellations
We ask that you give us 24-hours notice when possible for canceling or rescheduling appointments.

Preparation
At the time of your visit, you will be asked to present the following:

- ❑ copay, if applicable
- ❑ enclosed forms, completed
- ❑ health insurance card(s) & photo ID
- ❑ current medications, including dosage and strength & current immunization records
- ❑ previous medical records, or arrange for your previous physician to send records

24/7 ADVICE & SUPPORT

During business hours, we are happy to answer general questions over the phone. Urgent matters will be addressed before the day is over.

For less urgent matters, we will return your call within 24-48 hours.

For after-hours advice, we offer a Pediatric Nurse Advice Line that can assist you with your questions. You can access this service by calling 541-884-1224 and following the prompts.

If you feel your child has an urgent medical problem during business hours, please call our office to speak with a member of our staff. If the office is closed, please follow the prompt to speak with the after hours advice line.

Please contact us before going to an urgent care clinic or the ER. In most cases, we can treat your child in our clinic, saving you time and worry.

Location
2580 Daggett Avenue
Klamath Falls, OR 97601
Ph: 541-884-1224
Fax: 541-884-8030

Office Hours
Monday – Friday
8:00 AM – 5:00 PM

visit us online at:

www.cckonline.com

The Children's Clinic of Klamath

Authorization to Release Medical Records

Patient Name: _____ _____ Date of Birth: _____
(Please print full name.)

Address: _____
(Street City State Zip Code)

Phone Number: _____

Release Purpose: Self _____ Changing provider _____ Consultation _____ Legal _____
Two years of records sent to other physicians/clinics are provided free of charge. Any additional records (more than 2 years) will be charged at the rate set by Oregon Statute. ORS 192.521: $30 for copying 10 or fewer pages of written material, $0.50 per page for pages 11 thraugh 50, $0.25 for each additional page. Postage fees if sent by first class mail, thumb drive or disc charges if requested. Please make payment toThe Children's Clinic of Klamath. Your request will be processed within 30 days after payment.

I authorize my health information to be: Sent to _____ Requested from _____

Name: _____ Phone: _____ Fax: _____

Address: _____

My medical information: MAY _____ MAY NOT _____ be securely faxed.
My medical information: MAY _____ MAY NOT _____ be securely emailed.

The Children's Clinic of Klamath will accept medical records via secure fax to (541) 884-8030 or securely emailed to: nurses@cckonline.com. We also accept records through the mail or via drop off in office.

General Medical Records: _____
excluding protected records. Copies will be limited to 2 years of information.

Specific Information only: _____
Medications, Labs, Pathology, EKG, Imaging, Immunizations, Test results

I understand that certain information cannot be released without specific authorization as required by State/Federal law. By INITIALING, I authorize information. Patients 14+ must provide initials.

Initials _____ Drug and alcohol diagnosis/treatment
Initials _____ ADD/mental health treatment
Initials _____ AIDS/HIV test results

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.
You are under no obligation to sign this form, and you may refuse to do so. Treatment, payment, enrollment, or eligibility benefits may not be conditioned on signing this authorization, with the exception of obtaining information in connection with eligibility or enrollment in a health plan.

You have the right to revoke this authorization at any time by providing a written request for revocation to The Children's Clinic of Klamath Medical Records Department. If you revoke the authorization, the revocation will not affect any disclosures that were made prior to processing the revocation request. Unless otherwise revoked, this authorization will expire 1 year from the date signed or will expire on the following date, event, or condition: _____

Signature of parent or legal guardian: _____ Printed name: _____

Relationship to patient: _____ Date: _____

Signature of patient if over 14 years of age: _____ Printed name: _____
Minors - a minor patient's signature is required in order to disclose information reloted to reproductive care, sexually transmitted diseases, HIV/AIDS drug and/or alcohol abuse, mental health.

The Children's Clinic of Klamath
2580 Daggett Ave Klamath Falls, OR 97601
PH: 541-884-1224 Fax: 541-884-8030

The Children's Clinic of Klamath

New Patient Information

2580 Daggett Avenue
Klamath Falls, OR 97601
541-884-1224/fax 541-884-8030
www.cckonline.com

PARENT INFORMATION

Name: _____
Last First MI

SSN: _____ DOB: ___/___/___ ❑ M ❑ F

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Address: _____

City/State/Zip: _____

Email: _____

Home: (____)_____ Cell: (____)_____

How did you hear about us? _____

OTHER PARENT INFORMATION

Name: _____
Last First MI

SSN: _____ DOB: ___/___/___ ❑ M ❑ F

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Address: _____

City/State/Zip: _____

Email: _____

Home: (____)_____ Cell: (____)_____

PATIENT INFORMATION

New Patient? ❑ Y ❑ N

Name: _____
Last First MI

SSN: _____ DOB: ___/___/___ ❑ M ❑ F

OTHER CHILDREN IN FAMILY

Patient Here? ❑ Y ❑ N

Name: _____
Last First MI

SSN: _____ DOB: ___/___/___ ❑ M ❑ F

.....Patient Here? ❑ Y ❑ N.....

Name: _____
Last First MI

SSN: _____ DOB: ___/___/___ ❑ M ❑ F

.....Patient Here? ❑ Y ❑ N.....

Name: _____
Last First MI

SSN: _____ DOB: ___/___/___ ❑ M ❑ F

EMERGENCY CONTACT (other than spouse)

Name: _____
Last First MI

Relationship to Patient: _____

Home: (____)_____ Cell: (____)_____

BILLING INFORMATION

❑ Private Pay (no insurance)

❑ Insurance (primary) Eff. Date: ___/___/___

Insurance Co: _____

Employer: _____

Policyholder: _____ DOB: ___/___/___

Policy #: _____

Group #: _____ Copay: $ _____

❑ OHP (circle one): CHA | DMAP

❑ Insurance (secondary) Eff. Date: ___/___/___

Insurance Co: _____

Employer: _____

Policyholder: _____ DOB: __/___/____

Policy #: _____

Group #: _____ Copay: $_____

CONSENT FOR TREATMENT: I authorize the physicians and clinic personnel of The Children's Clinic of Klamath to conduct physical examinations and routine services, order and perform tests, and administer treatment deemed necessary by the examining physician. Should treatment be performed, the physician will fully inform me as to the nature of the procedure, the alternatives to treatment, and the risks involved. I will be given the opportunity to ask questions and have my questions answered. Should special procedures be indicated, I understand that the examining physician will discuss this with me and that additional consent(s) may be required .

FINANCIAL RESPONSIBILITY: I understand that I am responsible for all charges resulting from treatment provided by The Children's Clinic of Klamath, as well as any agency and/or legal fees incurred should my account be placed in a collection status. I agree to pay the balance due within 30 days of statement billing unless I have made other payment arrangements.

ASSIGNMENT OF BENEFITS: I authorize my insurance carrier(s) to remit payment of benefits for any claim to The Children's Clinic of Klamath I understand that any ineligible or non-covered expenses are my responsibility.

I assign The Children's Clinic of Klamath, as an Authorized Representative to: (1) Submit any and all appeals when my insurance company denies me benefits to which I am entitled, (2) Submit any and all requests for benefit information from my insurance company, (3) Initiate formal complaints to any state or federal agency that has jurisdiction over my benefits, and (4) Release all medical information necessary to process my claims. I authorize any plan administrator or insurer to release any and all plan documents, insurance policy, and/or settlement information upon written request. This assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare, and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original.

X_____ _____ X_____/_____/_____

Signature of Patient/Parent/Legal Guardian | Print Name | Relationship to Patient | Date

FAMILY HISTORY

Have any family members had the following conditions? Please mark an 'X' by each condition that applies.

Family Member Name:	Date of Birth:	Lives with patient?	No Known Problems	Other	ADHD	Allergy-Severe	Arthritis	Asthma	Birth Defects	Bleeding Problem	Clotting Disorder	Depression	Developmental Delay	Diabetes	Early Death	Eczema	Hearing Loss	Heart Defect	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Disease	Obesity	Rheumatologic Disease	Seizures	Substance Abuse	Sudden Death	Thyroid Disease	Vision Loss
Mother:	/ /																											
Father:	/ /																											
Sibling:	/ /																											
Sibling:	/ /																											
Maternal Gma:																												
Maternal Gpa:																												
Paternal Gma:																												
Paternal Gpa:																												
Other:	/ /																											

List any other conditions (by family member):

The Children's Clinic of Klamath
NewPatient Information

2580 Daggett Ave
Klamth Falls, OR 97601
Ph: 541-884-1224 Fax: 541-884-8030

Full legal name of patient: _____ Date of Birth: _____

Preferred name (what you like to be called): _____ Sex: Male ___ Female ____ Other _____

Gender Identity: Male ____ Female ____ Transgender male ____ Transgender female ____

Sexuality: Heterosexual/Straight _____ Bisexual _____ Gay _____ Lesbian _____ Unsure _____

Pronouns: She/Her/Hers _____ He/Him/His _____ They/Them/Theirs _____

Ethnic group: Hispanic Non-Hispanic

Race (circle all that apply): White Native American African American Alaskan Native Native Hawaiian Pacific Islander
Other (please specify): _____

Parent/Guardian phone number: _____

Do we have permission to leave a detailed message and/or confidential information on the voicemail of this number?
Yes _____ No _____

Employment Status

Full Time _____ Part Time _____ Retired _____

Unemployed _____ Self Employed _____

Relationship to Patient:
Parent: _____ Step Parent: _____
Foster parent: _____ Other: _____

Parent/Guardian phone number: _____

Do we have permission to leave a detailed message and/or confidential information on the voicemail of this number?
Yes _____ No _____

Employment Status

Full Time _____ Part Time _____ Retired _____

Unemployed _____ Self Employed _____

Relationship to Patient:
Parent: _____ Step Parent: _____
Foster parent: _____ Other: _____

Would you like to receive appointment reminders via Phone call: _____ Text: _____ Email: _____

Do you have any concerns regarding having enough food to eat? Yes _____ No _____

Do you have any concerns regarding housing? Yes _____ No _____

Do you have any concerns regarding your transportation? Yes _____ No _____

"Growing Up Together"
2580 Daggett Ave
Klamath Falls, OR 97601
Ph: 541-884-1224
Fax: 541-884-8030
cckonline.com

The Children's Clinic of Klamath
Clinic Policies

Thank you for choosing The Children's Clinic of Klamath for your child's medical care. Please review the following policies and procedures below and sign where indicated.

Patient Name: _____ Date of Birth: _____

- Patient's must arrive 15 minutes before their scheduled appointment time. Please provide their insurance card and insurance copay if applicable at check in. We have a contractual obligation to your insurance company to collect copays at the time of service.
- Any outstanding balances due to deductibles, co payments and services not covered by your insurance are your responsibility. All balances must be paid promptly. If you are unable to pay the balance in full please contact our billing office at 541-882-1540 to make payment arrangements. Non-payment of charges will result your account being turned over to a collection agency and your family may be discharged from the practice.
- A no show or late cancellation fee of $50 may be charged to patients who do not provide a 24 hour notice to cancel an appointment or for patients who have "no call no showed" their appointment. After 3 no shows or late cancellations you may be discharged from the practice.
- If you arrive more than 15 minutes late for your appointment you may be asked to reschedule depending on the offices availability for the day.
- If your child is being seen for a well child check up and you have other concerns that are not related to routine wellness care, those concerns may generate additional charges to your insurance and you may be asked to schedule another appointment to discuss these concerns.
- Our office is open Monday through Friday 8:00am to 5:00pm. After hours we offer a telephone triage consultation that puts you in touch with a pediatric trained nurse. You may reach this service by calling our office and following the prompts. We offer this service to help save on costs and high wait times for possibly unnecessary trips to Urgent Care or the Emergency Room. You may also find the answers to your questions on our website at cckonline.com.
- Please allow 3 business days for all requested forms and prescription refill requests.
- The Children's Clinic of Klamath will only use and disclose health information about the patient in compliance with the HIPAA Act. You are entitled to a copy of the Notice of Privacy Practices as outlined by Federal Regulations. You have the right to ask that some or all of the patients health information to not be disclosed in the manner described in the Notices of Privacy Practices. The Children's Clinic of Klamath is not required by law to agree to such requests. Your signature below acknowledges that you are aware of your rights in accordance with HIPAA.
- We keep a record of health care services that we provide to your child. You may ask to see that record (copy charges may apply). You may ask us to correct that record, although we may not agree. We will not disclose your child's record to others unless you direct us to do so or unless the law authorizes or compels us to do so. Please contact us to see the records or get more information.

I, _____ the parent or legal guardian of _____
Authorize and consent to routine and emergency medical treatment for my child when deemed necessary by qualified medical personnel. This authorization will be in effect until revoked.

I acknowledge with my signature that I have read and understand the above information.

Parent/Guardian Signature: _____ Date: _____

The Children's Clinic of Klamath Financial Policy

We are committed to providing you with the best care possible. This goal is best achieved if everyone is aware of our policies. Your clear understanding of our financial policy is important to our professional relationship.

INSURANCE:

Payment for services is due at the time services are rendered, except as outlined below. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered. It is the responsibility of the patient to provide **ACCURATE** and **TIMELY** insurance information. Inaccurate or untimely information given to the staff that results in denial or non-coverage by your insurance company will result in the guarantor/patient being responsible for payment. All patient balance questions should be made directly to your insurance for an explanation of benefits.

NON-EMERGENCY APPOINTMENTS:

Well visits, physicals, any non-emergent follow ups and visits may be rescheduled if there are outstanding balances or co-pay is not paid at time of service. If you are experiencing financial difficulty, please let us know. Health insurance is a contract between you, your employer and your insurance company. It is important for you to be an informed consumer who understands the specifications of your insurance policy (including vaccine and doctor visit coverage, referral/authorization requirements for specialty care, x-rays, lab tests, emergency hospital care, ect.).

BILLING:

We accept cash, checks, American Express, Discover, MC or Visa. Co-pays are due at the time of service. Deductibles and any patient responsible balances will be billed to the patient. Outstanding balances are due within 30 days of the statement date, unless prior arrangements have been made with the office. Balances not paid within the 30 days of the first statement date may be subjected to cancellation of your next appointment. Balances not paid in full within 90 days of the initial statement date will be forwarded to a collection agency. If your account is sent to collections a second time, your family will be dismissed from our practice.

A $35.00 fee will be charged for all returned checks and your account will be placed on a "cash or credit card basis only." We will accept payments by cash or credit card only until the balance is cleared.

For any children seen, the accompanying parent or adult is responsible for full payment at the time of service. In case of divorce, please do not place our office in the middle of marital/custodial disputes. It is your responsibility to work out the payment of your child's medical care between the custodial and non-custodial parent.

We realize tbat temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact our billing office promptly at 541-882-1540 for payment arrangements and assistance in the management of your account.

Should your account balance become un-collectible due to bankruptcy, you could possibly be discharged from the practice.

IF WE DO PARTICIPATE WITH YOUR INSURANCE COMPANY:

All services performed in our office and at the hospital will be submitted as a courtesy to your insurance. All co-pays are due at time of service. Deductibles and coinsurance are your responsibility and will be billed to you by our office. Not all services provided by this office are a covered benefit with all insurance plans. You may be asked to sign a waiver that you understand this and may be responsible for the costs.

IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE COMPANY:

We are not able to bill your insurance and we cannot accept payment from them for the services performed. We will provide you with an itemized bill so that you may submit the charges to your insurance company for reimbursement. ***Be prepared that you will not always be reimbursed the full price amount you paid for your services by our physician. We will not reimburse you the difference between the reimbursement rate your insurance pays you and our fee for our services. Payment for services is due at the time of service.

MISSED APPOINTMENT/LATE CANCELLATIONS:

Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. We reserve the right to charge a $50.00 fee for any missed appointments. We request that you cancel any appointments at least 24 hours in advance of your appointment time. We understand that emergencies happen, please reach out to us as soon as possible regarding your missed appointment. After three missed appointments without notification, our office may discharge you from the practice.

ASSIGNMENT AND RELEASE:

I hereby authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for non-covered services. I also authorize the physician to release information required in the processing of insurance claims.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY THE CHILDREN'S CLINIC OF KLAMATH. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, MY FAMILY MAY BE DISCHARGED FROM THE PRACTICE. I UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT/GUARANTOR.

Signature of Patient/ Responsible person:_____

Print name:_____

Date:_____

The Children's Clinic
of Klamath

Nondiscrimination Policy

It is the policy of The Children's Clinic of Klamath to not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, national origin, religion, gender, sexual orientation, marital status, disability, or ability to pay, for receipt of the services and benefits of any of its programs and activities or in employment therein, whether carried out by The Children's Clinic of Klamath directly or through a contractor or any other entity with whom the clinic arranges to carry out its programs and activities.

This policy is in accordance with the provisions of Title VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to the Acts, Title 45 code of Federal Regulations Part 80, 84, and 91 including, but not limited to other Federal Laws and Regulations that provide similar protection against discrimination.

In case of questions concerning this policy, or in the event of a desire to file a complaint alleging violations of the above, please contact us at 541-884-1224.

The Children's Clinic

of Klamath

DISCOUNT FEE POLICY

It is the policy of The Children's Clinic of Klamath to provide essential medical services regardless of the patient's ability to pay.

We will not discriminate against any person receiving health services because of their inability to pay for services, or because payment for the health services will be made under part A or B of title Xviii (Medicare) or title XiX (Medicaid) of the Social Security Act.

We will accept assignment under the Social Security Act for all services for which payment may be made under part B of title Xviii (Medicare) of the act.

We have an agreement with the State agency which administers the State plan for medical assistance under title XiX (Medicaid) of the Social Security Act to provide services to persons entitled to medical assistance under the plan.

Discounts are offered for cash pay if paid at the time of service.

2580 Daggett Avenue - Klamath Falls, OR 97601
Office (541) 884-1224 - Fax (541) 884-8030
www.cckonline.com

Rev 10/2025

Genetic Privacy Notice

Notice of Your Right to Decline Participation in Future Anonymous or Coded Genetic Research

The Children's Clinic of Klamath is required by Oregon law to provide this notice to you regarding the use of your health information or biological samples for genetic research (OAR 333-025-0100-333-025-0165).
State law protects the genetic privacy of individuals and gives you the right to decline to have your health information or biological samples used for research.
A biological sample may include a blood sample, urine sample, or other materials collected from your body. You can decide whether to allow your health information or biological samples to be available for genetic research. Your decision will not affect either the care you receive from your health care provider or your health insurance coverage.
Research is important because it gives us valuable information on how to improve health, such as ways to prevent or better treat heart disease, diabetes and cancer. Under Oregon law, o special team reviews all genetic research before it begins. The team makes sure that the benefits of the research are greater than any risks to participants.
In anonymous research, personal information that could be used to identify you, such as your name, Social Security number or medical record number, cannot be linked to you health information or biological sample. In coded research, personal information that could be used to identify you is kept separate from your health information or biological sample, making it very difficult to link your personal information to your health information or biological sample. Your identity is protected in both types of research.
If you **DO NOT** want to have your health information and biological sample available for anonymous or coded genetic research. **YOU MUST** tell your health care provider by, signing and returning the form as directed by your clinic representative.

GENETIC PRIVACY OPT OUT STATEMENT
I have read and understand the above Genetic Privacy Notice and I DO NOT want to have my or my child's health information and biological samples available for anonymous or coded genetic research.

Patient Name: _____ Date of Birth: _____

Patient or personal representative printed name: _____

Signature: _____ Date: _____

Relationship to patient: _____

If you want to allow your health information and biological sample to be available for anonymous or coded genetic research and make this choice, your health information or biological sample may be used for anonymous or coded genetic research without further notice to you.
No matter what you decide now, you can always change your mind later by completing this form and returning it to your health care provider. Your new decision is effective on the date your health care provider receives the Genetic Privacy Opt Out form. and will apply only to health information or biological samples collected after your health care provider receives the form. If you have questions about Genetic Testing, please call the Oregon Genetics Program at 971-673-0271.
This form will be retained in your medical chart throughout your relationship with The Children's Clinic of Klamath.
Sincerely,
The Children's Clinic of Klamath

14 years and Older Release of Information

Patient Name: _____

Date of Birth: _____ Age: _____

Patients Phone Number: _____

It is okay for The Children's Clinic of Klamath to leave a detailed message on my voicemail, including test results. **Initials:** _____

I give my permission for The Children's Clinic of Klamath to contact my parents/guardians regarding test results. **Initials:** _____

I give my parents/guardians permission to access my medical records through the patient portal or request them on my behalf. **Initials:** _____

Parent/Guardian Name: _____

Parent/Guardian Name: _____

I **DO NOT** give my parents/guardians to access and/or view my medical records or receive test results. **Initials:** _____

Printed name of patient: _____

Signature of patient: _____

Date: _____

Notice of Privacy Practices (HIPAA)

Effective Date: _____

Purpose

This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully.

Our Responsibilities

We are required by law to:

- Maintain the privacy of your protected health information (PHI)
- Provide you with this notice of our legal duties and privacy practices
- Abide by the terms of this notice

How We May Use and Disclose Your Information

We may use or disclose your PHI for the following purposes:

- **Treatment:** To provide, coordinate, or manage your healthcare.
- **Payment:** To obtain reimbursement for services provided.
- **Healthcare Operations:** For administrative, educational, and quality improvement activities.
- **As Required by Law:** To comply with legal obligations.
- **Public Health and Safety:** For reporting diseases, abuse, or threats to public safety.
- **Business Associates:** To third-party vendors who perform services on our behalf.

Your Rights

You have the right to:

- **Access:** Request to view or obtain a copy of your medical records.
- **Amend:** Request corrections to your health information.
- **Restrict:** Ask us to limit certain uses or disclosures

- **Confidential Communications:** Request that we contact you in a specific way.
- **Accounting of Disclosures:** Receive a list of disclosures we've made.
- **Paper Copy:** Request a paper copy of this notice at any time.

Patient name: _____ Date of Birth: _____

Parent name: _____ Date of Birth: _____

Parent signature: _____

Contact Information

If you have questions or wish to exercise your rights, please contact:

The Children's Clinic of Klamath
2580 Daggett Ave Klamath Falls, OR 97601
Phone: 541-884-1224 or Fax: 541-884-8030
Email: nurses@cckonline.com or reception@cckonline.com

The Children's Clinic
of Klamath

Authorization to Treat in the Absence of Parent or Guardian
I authorize the following person(s)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

To be present at any exam and consent to treatment by any provider at The Children's Clinic of Klamath.
This authorization is for my child/children:

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Parent/Guardian printed name: _____

Parent/Guardian signature: _____

Address: _____ Phone: _____

Date: _____

Not applicable at this time. Signature: _____ Date: _____

The Children's Clinic of Klamath
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Ph: 541-884-1224 Fax: 541-884-8030
cckonline.com