Archangel Michael Health

Consent to Treat a Minor & Minor Assent

Christopher L. Bray, MD, PhD, CPE, FACP — board-certified in Internal and Integrative Medicine

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1. Patient (Minor) Information

Full Name of Minor: _____

Date of Birth (MM/DD/YYYY): _____ **Age:** _____

Home Address: _____

City, State, ZIP: _____

2. Parent/Legal Guardian Information

Name of Parent/Legal Guardian: _____

Relationship to Minor (e.g., mother, father, legal guardian): _____

Phone — Home: _____ **Cell:** _____

Email (optional): _____

Address (if different from minor): _____

City, State, ZIP: _____

3. Eligibility & Age Policy

> "Archangel Michael Health accepts patients aged 16 and older. By exception and at Dr. Bray's sole discretion, patients aged 14–15 may be accepted **solely for integrative and lifestyle medicine consulting** when all of the following are met: (1) a parent or legal guardian provides written consent and participates in all visits; (2) the minor maintains an ongoing relationship with a pediatrician or family physician who continues to provide their primary medical care; and (3) services provided by Archangel Michael Health are consultative and complement — and do not replace — the minor's primary care. Archangel Michael Health does not serve as the primary care provider for patients under 16."

4. Authorization for Medical Evaluation & Treatment

I, the undersigned parent or legal guardian, hereby authorize Archangel Michael Health, PA and its healthcare providers to perform medical examinations, evaluations, and treatments deemed necessary for my minor child named above. This includes, but is not limited to:

- Telehealth consultations (where applicable)
- Routine medical examinations
- Diagnostic procedures (e.g., lab tests, imaging)
- Prescription or medication administration (as permitted by the practice)
- Other non-emergency healthcare procedures deemed necessary by the provider

In the event of an urgent or emergency situation when I am not present, I consent to such care and treatment as may be necessary to stabilize and protect the health of my child until I can be contacted for further instructions.

5. Written Consent Under Florida Law

Florida law (Parents' Bill of Rights, Fla. Stat. § 1014.06) requires a health care practitioner to obtain written parental or guardian consent before providing services to a minor. This signed form provides that consent. Narrow statutory exceptions exist under Florida law — for example, emergency care when a parent cannot be reached, and certain services minors may consent to on their own under Florida law — and nothing in this form limits those exceptions.

6. For Ages 14–15 Only — Exception Conditions

Complete this section only if the minor named above is 14 or 15 years old. The parent/legal guardian confirms each of the following by checking the boxes:

- ☐ Services from Archangel Michael Health, PA will be limited to integrative and lifestyle medicine consulting.
- ☐ I (the parent/legal guardian) will participate in all visits.
- ☐ The minor maintains an ongoing relationship with a pediatrician or family physician who continues to provide their primary medical care.

Pediatrician / family physician name and practice:

_____

7. Guardianship Documentation

If this form is signed by a legal guardian other than a parent, documentation confirming legal guardianship or custody must be provided to the practice.

☐ Legal guardianship/custody documentation received and reviewed. Staff initial: _____

☐ Not applicable — signer is the minor's parent.

8. Limitations or Special Instructions

If there are certain treatments or procedures you do not authorize, or any special instructions the healthcare provider should be aware of, please indicate them below:

_____

_____

9. Duration of Consent

This consent remains in effect until revoked in writing by the undersigned or until the minor reaches the age of 18, whichever occurs first, unless an earlier expiration date is specified below.

Expiration Date (optional, MM/DD/YYYY): _____

10. Minor Assent (for minors age 13 and older)

To be read and signed by the minor patient, in their own words:

"The doctor and my parent/guardian explained what this practice does. I agree to take part in my care, answer honestly, and ask questions when I don't understand something. I know I can talk to the doctor or my parent/guardian at any time if something worries me."

MINOR'S SIGNATURE (ASSENT)	MINOR'S PRINTED NAME	DATE (MM/DD/YYYY)

11. ACKNOWLEDGMENT & SIGNATURE

By signing below, I acknowledge that I have read, understand, and agree to the terms of this Consent to Treat a Minor. I affirm that I have the legal right to consent to medical treatment for the minor named above, and I understand this signed form provides the written parental/guardian consent required by Florida law.

SIGNATURE OF PARENT/LEGAL GUARDIAN

PRINTED NAME

RELATIONSHIP TO MINOR

DATE (MM/DD/YYYY)

For office use only

RECEIVED BY (STAFF MEMBER)

DATE RECEIVED

Archangel Michael Health, PA · 352-441-9110 · fax 352-441-9114 · archangelmichaelhealth.com