Consent for Procedure/Treatment of Minor Child

Patient Name: ___________________DOB: ______________Social Security #:______________________

I authorize and direct __________________________, M.D. and his or her assistants to

perform medical care including procedures/treatment.

The person authorized to request medical care and or treatment on my behalf is:

Name _________________________________ Address __________________________________

Phone Number______________________________ Relationship to Patient __________________

To act on my behalf in authorizing medical treatment for the above named minor during the period of:

(1) From _________________________ to _______________________

OR

(2) From ______________________________and ongoing until I revoke this authorization in writing.

Financial Responsibility

I understand that payment is expected at the time of services and will insure that the above mentioned caretaker has the required insurance information and the means to pay the co-pay/co-insurance due at the time of service. I accept full responsibility for charges accrued in the healthcare of my child if the physician is unable to collect from my insurance company.

_______________________________ ____________________________ __________________

Signature of Parent/Legal Guardian Printed Name of Parent/Legal Guardian Date

***Signature of parent must match the signature on file in our office**

***If a patient has never been seen in our office a copy of parents/legal guardian's driver license must be attached**

***If legal guardian is signing, a copy ofguardianship papers must be on file in our office.**

For Office Use Only

Caretaker's Driver License#_______________________ verified by _______ Date_________