Children's Choice Pediatrics

TREATMENT AUTHORIZATION FOR MINORS

We recognize that parents may not always be able to be available or present during needed treatment of their young child or teen. This form addresses the situation when your child needs to be seen and has come in either alone or accompanied by another adult/guardian.

I, (Parent/Guardian)_____
(Picture ID must be on file)

Authorize my child:_____

Child's Date of Birth:_____/_____/_____

May be treated: (Circle Designation) **UNACCOMPANIED** **ACCOMPANIED**

If child ***must*** be accompanied, authorized persons are:

_____ (Must have Picture ID at EACH visit)

_____ (Must have Picture ID at EACH visit)

_____ (Must have Picture ID at EACH visit)

_____Initial here if you wish to give consent for the minor to receive medical care without an accompanying adult, which shall be in effect for: _____ days only, or
_____ (initial here) indefinitely, until revoked by written communication.

Please be advised that we will not be able to perform any invasive procedures unless a parent or legal guardian accompanies the minor to their appointment. If such services need to be performed, another appointment will need to be scheduled in which the parent or legal guardian must be in attendance.
It is the policy of this office that the adult presenting the child for treatment, or the child if they are seen without an adult present, is responsible for payment of the patient portion at the time of service.
I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand.

_____ _____ _____
Parent or Legal Guardian Signature Relationship to Patient Date