Consent for Procedure/Treatment of Minor Child

Patient Name: ____________________ DOB: ___________Social Security#:_________________

I/We authorize and direct__________________________, M.D. and his or her assistants as necessary to perform medical care including procedures/treatment.

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

Name _____________________________________ Address _____________________________

Phone Number _______________________________ Relationship to Patient ________________

To act on my/our 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/We 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/We accept full responsibility for charges accrued in the healthcare of my child if the physician is unable to collect from my/our insurance company.

_________________________________ _______________________________ ______

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

_________________________________ _______________________________ _______

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 guardians driver license must be attached**
- **If legal guardians is signing a copy of guardianship papers must be on file in our office**

For Office Use Only

Caretakers Driver License #______________________ verified by ________ Date__________