Consent for Procedure/Treatment of Minor Child

Patient Name: _____
Last Name **First Name** **Middle Initial**

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: _____
Last Name First Name Middle Initial

Address _____
Street City State Zip Code

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/coinsurance 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

Caretaker's Driver License _____ _____ verified by _____ Date_____
State Number