CONSENT TO TREAT MINORS

Prior authorization is required by Flower Mound Family Physicians in order to treat a minor (a patient under the age of 18) without the presence of his/her parent or legal guardian. With this document you may appoint anyone who is over the age of 18 to accompany your child to their medical appointment.

Minor's full name: _____ Date of Birth: _____

In my absence, I authorize the following individuals to accompany my child.

_____ _____ _____

Name Relationship Telephone

_____ _____ _____

Name Relationship Telephone

_____ Initial here if you wish to give consent for the minor to receive medical care without an accompanying adult. **This shall be in effect 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 is present. If such services need to be performed, another appointment will need to be scheduled for the procedure. It is a policy of this office that the adult accompanying the child or the child alone is responsible for the payment of the patient portion at the time of service.

I have read and understand this form and give my consent to Flower Mound Family Physicians to treat my child.

_____ _____

Signature of Parent/ Legal Guardian **Date**