Wm. Scott Athans, OD
Michele P. Keel, OD
Keith P. Poindexter, OD

Authorization to Administer Care to Patients who are Minors

Patients Name: _____ Date: _____

Responsible parties name and relationship to patient:
_____

I _____ the responsible party for the above patient who is a minor give permission for Spectrum Eye Center, it's staff and doctors to complete the following services without my physical presence in the office.

o Exam	**o Contacts Lens Exam**	**o Topography**
o Contacts Lens Fitting	**o Biometry**	**o Digital Photos**

I understand that it is the desire of Spectrum Eye Center to perform a complete and thorough eye examination and to only perform what services are necessary without my presence. However, I leave the decision making responsibility to the doctors and staff to determine what test will/may be necessary. I will in no way hold the office, staff or doctors responsible for the charges, procedures or medical decisions that were made to complete the above mentioned services.

I understand and agree with the requirements noted above.

_____	_____
Responsible Party (Print name)	**Date**
_____	_____
Signature of Responsible Party	**Date**
_____	_____
Witness	**Date**

160 Fox Hollow Court
Pinehurst, NC 28374

Email:spectrum@pinehursteyes.com
Website: myspectrumeyes.com

Phone: (910) 692-3937
Fax:: (910) 692-5908