CONSENT TO TREAT

Labs/Procedures/Immunizations/ Vaccines/Injectables

I voluntarily authorize and consent to the medical care, treatment, diagnostic tests, transfers, and referrals that the providers at Pediatric Center at Renaissance and their designated associates or assistants believe are necessary. I also consent to the taking of photographs related to the care and treatment of the patient and understand that such photographs may be made part of the medical record. l understand that by signing this form, I am giving permission to the doctors, physician assistants, and other health care providers in this medical office to provide treatment as long as a physician/patient relationship exists, or until I withdraw my consent.

List of Name of Patient(s):

____

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At times you may not be able to bring your child in for treatment. Please specify any other adult 18 years or older that is able to act on your behalf in authorizing medical treatment: (i.e., grandparent, aunt, uncle, etc.). Please check next to the person that you want as the emergency contact in case we are not able to get a hold of either parent/guardian.

Name	Address	Phone #	Relationship

Permission to Treat Patients 16 Through 18 Years Old without Parent/Legal Guardian

Pediatric Center at Renaissance must receive permission, from a child's parent or legal guardian, prior to providing treatment(s) for preventative care, injury, or illness that is non-life threatening. This form provides the legal permission to treat your adolescent child without an adult present.

Patient's Name: ____ Patient's DOB: ______________

This form is specific to patients who are at least 16, but not 18 years old. In addition to giving permission to Pediatric Center at Renaissance to assess and treat the aforementioned minor without an adult present, I also agree to be financially responsible for payment of all charges in connection with the care and treatment rendered.

This authorization is valid until otherwise revoked or until date listed ____________________________.

Please note: insurance card(s) and co-pay amounts (if applicable) must be presented at each visit.

Authorized by: ____ Date: ______________________

(Parent/legal guardian signature)