RIVER RIDGE PEDIATRICS, P.A.

CONSENT TO TREAT

Patient Name: _____ DOB: _____

CONSENT FOR TREATMENT

I hereby authorized evaluation and treatment by the physicians and staff associated with River Ridge Pediatrics, P.A. I understand and agree that the signatures and dates on this form will not expire without written notice or in the case that a minor becomes the age of 18, and that a photocopy of this form is considered valid as the original.

_____

Parent or Legal Guardian (Please Print) / Relationship

_____ _____

Parent or Legal Guardian (Signature) Date

CONSENT TO TREAT PATIENT – WITHOUT PARENT PRESENT

I hereby authorize _____to

Name/Relationship

bring my child to his/her appointments if I am unable to attend. I understand that medical advice will be relayed to them on my behalf.

_____

Parent or Legal Guardian (Please Print) / Relationship

_____ _____

Parent or Legal Guardian (Signature) Date