

Permission to Treat Minor Patient without Parent/Legal Guardian Present

Today's Date: _____

Clayton Medical Associates, P.A. 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 (depending on the minor's age) either treat without any adult present (Section A), or with a Designated adult present (Section B)

Patient's Name _____ Patient's DOB: _____

Section A: (ONLY for child at least 16, but not 18 years old)

Authorization to treat your minor child in case you or your designated representative are unable to accompany your child to one of his/her visits: I, (print parent/legal guardian name) _____ grant Clayton Medical Associates, P.A. permission 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 and understand that past due balances, copays, and deductibles are due at the time of service.

Section B: (for child under 18 years old)

Delegation of authority for medical treatment of a minor child to the designated representative indicated below: I, (print parent/legal guardian name) _____ grant Clayton Medical Associates, P.A. permission to assess and treat the aforementioned minor in the presence of either of the following adults (you may choose more than one), who is authorized to approve treatment:

Name: _____ Relation to minor: _____
Name: _____ Relation to minor: _____

I also agree to be financially responsible for payment of all charges in connection with the care and treatment rendered and understand that past due balances, copays, and deductibles are due at the time of service.

NOTE: A parent / legal guardian MUST be present for a minor patient's first visit with Clayton Medical Associates.

This visit only (date of appointment): _____

OR

This authorization is valid until the minor child turns 18: _____ (Initial)

Please Note: Insurance card(s) must be presented at each visit. In addition, past due balances, copays, and deductibles are due at the time of service.

Authorized by: _____ Date: _____
Parent or Legal Guardian

Parent or Legal Guardian Emergency Contact Phone #1 _____

Parent or Legal Guardian Emergency Contact Phone #2 _____