Date _____ **HENDERSONVILLE PEDIATRICS, P.A.** Chart # _____

Please Use Gel Pen or Other Dark (Black) Pen to Complete

CONSENT FOR TREATMENT OF UNACCOMPANIED MINOR

PATIENT INFORMATION

Legal Name: _____ Date of Birth: _____/_____/_____

Phone Number: _____ Email Address: _____

Parent(s) / Legal Guardian(s) Name(s): _____

Parent(s) / Legal Guardian(s) Phone Number(s): _____

CONSENT TO TREAT

I agree that: (1) I am the minor's parent or legal guardian and I have the authority to sign this form without the approval of any other person or entity, or (2) I have the legal authority to consent to all forms of healthcare for minor.

I agree to be responsible for payment of all charges that are not paid by insurance. I authorize Hendersonville Pediatrics, P.A. to bill my insurance on file. I understand that any and all other payments are due at the time of service.

This permission applies to when a minor child is alone:

I agree that the practice can provide necessary medical care and treatment (including, but not limited to drugs, testing, vaccines, and procedures). This consent does not apply to surgery or invasive procedures, general anesthesia, or psychotropic drugs. I understand that if the minor has come to Hendersonville Pediatrics, P.A. for emergent medical treatment, the practice will try to notify me by phone. I give permission to the minor named above to seek necessary medical care in my absence.

I understand that this consent is valid from the date signed until revoked in writing by the patient's Parent(s) / Legal Guardian(s) or when the patient is no longer a minor.

Parent(s) / Legal Guardian(s) Signature: _____

Print Name(s): _____ Date: _____/_____/_____

AFFIRMATION OF MINOR

Unaccompanied Adolescent Minor's Affirmation:

I am an unaccompanied adolescent minor which means I came alone to this medical practice. I am seeking necessary medical treatment from Hendersonville Pediatrics, P.A.

Adolescent Minor (consenting to unaccompanied treatment): _____