16-17 Year Consent to Treat

Date: _____

I, _____, am the parent/guardian of

_____ (print name of patient). I have the right to consent to medical treatment for this patient. I have given this child consent to drive to your office in my absence.

I voluntarily authorize and consent to the medical care, diagnostic testing, and treatment that Regional Eyecare and their doctors and staff deem necessary for this child. I understand that by signing this form, I am giving permission to the doctors and staff at Regional Eyecare Associates to provide medical and routine vision care to this patient.

I acknowledge that this document is valid for:

_____ specific date of service _____

_____ one month from date on form

_____ one year from date on form

_____ as long as my child is a patient in this practice

And is binding only if this child remains an established patient in the practice. I agree that I am financially responsible for any services provided that are not covered by my insurance company. I understand that I have the right to withdraw my consent at any time.

Parent/Guardian Signature: _____

Phone Number: _____