Consent for Treatment of Minor Drivers (16yrs or older)

Goodlettsville Pediatrics, PC (GoodPeds)

Fax 888-599-5833

PURPOSE: This form may be used to allow minors of legal driving age (16yrs or older) to receive routine care and services at GoodPeds without a parent or proxy present.

For some families, it may be more convenient to have prior authorization in place that allows routine medical care to be delivered to minors if a parent or legal guardian cannot be present to provide consent. If you would like to have such a preauthorization in place, please review and complete the following form authorizing treatment for your minor child (age 16 or older) in advance.

AUTHORIZATION:

I have the legal right to preauthorize GoodPeds and its personnel to deliver routine medical treatment and services to my child. Routine medical care and interventions may include, but are not limited to: medical evaluation and advice, physical exam, administration of immunizations, lab work (examples include: throat or nasal swabs, blood draws, urine collection, wart treatment, debridement of minor burns, and incision & drainage of abscesses), and handling of prescriptions.

I request and authorize GoodPeds and its personnel to deliver routine medical care to my child listed below as may be deemed necessary or advisable in the diagnosis and treatment of the minor child.

Patient Full Name - _____

Date of Birth - _____

LIMITATIONS:

Identify any specific limitations on the kinds of medical services for which this authorization is given. If none, please state "None":

_____

Parental contact information for questions regarding treatment of the minor child:

Parent's Name _____ Parent's Name: _____

Daytime Phone: _____ Daytime Phone. _____

Evening Phone: _____ Evening Phone: _____

Cell Phone: _____ Cell Phone: _____

I hereby indemnify and hold harmless GoodPeds and all their officers, agents and employees from any liability for acting in reliance on this authorization. This authorization is valid following the date signed below unless withdrawn in writing. Only one parent's signature is required.

***I understand that any deductibles not met, copays, or balances should be arranged for payment as any other normal office visit when due at time of service.**

_____ _____

Signature of Parent or Legal Guardian Signature of Parent or Legal Guardian

Date _____ Date _____