PEDIATRIC ASSOCIATES, PC

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Permission to Treat Without Parent/Guardian Accompanying Child

In order for your child to receive care in our office, he/she must be accompanied by a parent or legal guardian at every visit. We understand that there may be times another caregiver has to bring a child to an appointment. In order for us to provide treatment in your absence, you must authorize another adult over the age of 18 years old to accompany your child. This form gives Pediatric Associates, PC legal permission to treat your child under the care of those authorized below. If this information is not on file with us or presented at the time of check in, we will be unable to provide treatment. We may only provide treatment to those authorized on this form, so we ask that you continue to update this accordingly.

Child's Full Name:	**DOB:**
1) _____	**1)** _____
2) _____	**2)** _____
3) _____	**3)** _____
4) _____	**4)** _____
5) _____	**5)** _____

Insurance co-pays and self pay charges are required at the time of service.

I give Consent by Proxy to:

1) _____

Last Name **First Name** **Relationship to Child**

2) _____

Last Name **First Name** **Relationship to Child**

as my proxy decision maker(s) for consenting to non-urgent medical care for my child(ren) listed above. I have the legal right to delegate such consent to the proxy decision maker, who is 18 years or older and legally and medically competent to exercise the authority so delegated.

Be advised that protected patient health information may be shared with the proxy to whom the right to consent has been delegated to facilitate informed decision making.

LIMITATIONS: *Identify any limitations on medical services for which this authorization is given.* ***If there are no limitations, state none.***

1) _____
2) _____
3) _____

TIME FRAME: *Specify the time frame for which the authorization is given.* ***If none, state none.***

Dates: _____ to _____

Name: _____ Relationship to Child: _____

Date: _____ Signature: _____