PACIFIC VISION MEDICAL CENTER

Permission to Treat a Minor without a Parent/Guardian Present

Minors that are <u>new patients MUST be accompanied by a parent or legal guardian</u>

Established Minor Patients:

Pacific Vision Medical Center must receive permission from a child's parent or legal guardian before providing an eye exam or any treatment from injury or illness that is non-life threatening. This form gives us legal permission to examine and treat your child in case you cannot accompany him/her to the clinic for their visit. If the party accompanying your child (baby-sitter, friend, relative, etc.) does not present this information, the clinic will attempt to contact you to request permission to examine and treat your child.

Note:

• *Minors may not receive an exam or treatment without a parent/legal guardian, unless the parent/legal guardian gives their consent for another adult party, must be 18 years of age, to accompany the minor patient for their appointment.*

• *The adult party accompanying the minor will be responsible for making any medical decisions when/if there is an emergency during the minor's appointment.*

• *A new "Permission to Treat a Minor without a Parent/Guardian Present" form is required for each visit that a minor will be seen without his/her parent/legal guardian*

• *Every three years a parent/legal guardian must accompany the minor patient for their appointment, in order for Pacific Vision Medical Vision to ensure appropriate insurance/billing information, signature of HIPAA forms, etc.*

Patient's Name: _____

Patient's Date of Birth: _____ Today's Date: _____

I grant _____ (an adult into whose care, the minor has been entrusted), to arrange for and authorize routine eye exam and/or treatment at Pacific Vision Medical Center on _____(date).

_____ Please initial here if you are authorizing the minor to seek and consent to an exam and treatment without parent/legal guardian present. We/I acknowledge that we are responsible for all reasonable charges in connection with the exam, care, and treatment rendered.

Please send the insurance card and co-pay (if applicable) to the appointment. Co-pays must be paid at time of service.

Name of Health Insurance Carrier:	
Group Number:	
Subscriber ID:	
Vision Insurance Carrier:	
Subscriber ID:	

In case of an emergency, I can be reached at:

Work Phone Number:	
Cell Phone Number:	

Signature: _____ Date: _____

Relation to patient (documentation may be requested): _____