Dr Black's Eye Associates

POLICY: CONSENT TO MEDICAL TREATMENT OF UNATTENDED MINORS

As a general rule, we require the consent of a parent or legal guardian in order to provide health care services to a minor child (someone under the age of 18). With so many parents working outside the home or with other commitments, we realize that you may not be able to accompany your child on every visit to the clinic. If your minor child presents to the clinic unaccompanied, we will not be able to see the unaccompanied minor. If the minor presents in the company of an adult other than a parent or legal guardian, they must have documentation from the parent or legal guardian giving consent for treatment. If they do not have a consent for treatment the appointment will be rescheduled.

In an effort to provide the care needed and avoid having to reschedule your child's appointment, we have developed a consent form that, once completed by a parent or legal guardian, will be placed in your child's medical record for use as necessary. This form will allow us to provide routine and medical treatment (including eye dilation) for your minor child when deemed necessary by qualified medical personnel. Adults, other than the parent or legal guardian who accompany a minor child to an appointment and are authorized by the Consent to Treat a Minor on record, will be asked to present photo ID upon checking the patient in for the appointment. This consent form will remain in effect until revoked in writing.

Patient name: **DOB:**

I, the undersigned, parent(s) or legal guardian of the above named patient, a minor, do hereby authorize the physicians at Dr Black's Eye Associates to act as agent(s) for the undersigned to consent to ocular examination, **dilation**, medical diagnosis and treatment or other medical care which is deemed advisable by, and is this is to be rendered under the general or special supervision of, the treating physician who is licensed to practice in the state of Indiana or Kentucky, whether such diagnosis or treatment is rendered at the office of said physician. **I further acknowledge that I am responsible for any portion of charges that are not covered by the child's insurance.**

Consent to treat a minor child accompanied by an adult other than the child's parent or legal guardian I, the parent or legal guardian of the patient named above, do hereby authorize the physician at Dr Black's Eye Associates to perform medical treatment as per the statements above when accompanied by either of the following names adult persons over the age of 18:

Adults name:_____PRINT NAME

Relationship to the child_____
(Grandparent, Aunt, Uncle, Sister, Brother, Family Friend)

Adults name:_____ PRINT NAME

Relationship to the child_____
(Grandparent, Aunt, Uncle, Sister, Brother, Family Friend)

This authorization is valid:

- For any and all routine or medical procedures (including installation of eye drops for eye pressure and dilation (Typically covered by insurance)
- Contact Lens evaluation, fitting and prescription (typically not covered in full by insurance)
- For Date of Service only: ____/____/_____

This authorization is valid until REVOKED IN WRITING (unless noted above)

Parent or Legal Guardian:_____Date:____/____/_____
signature

Parent or Legal Guardian:_____Date:____/____/_____
print name

Photo ID Verified _____ (Name/Initials of employee)