Consent for Treatment

Date: ___________________

I authorize the following (other than legal guardian or parent)

1. ____
2. ____
3. ____
4. ____
5. ____

to bring my minor child/children

____

Name(s) of Child(ren)

for medical treatment and care at Capote Pediatrics.

I further acknowledge that co-payments are due at time of visit with all caretakers and will make arrangements for such. Any co-payment not paid by caretaker will have an added $5 service charge per child. Also, any prior account balances may be discussed with caretaker to convey a reminder to the parent.

____

Printed Name of Legal Guardian

____

Signature of Legal Guardian

____

Witness