BALCONES WOODS FAMILY MEDICINE

Consent for Treatment of a Minor

Date: ______________

I, ____________________________, being the parent or legal guardian of ______________________, grant my permission for treatment at Balcones Woods Family Medicine by a licensed physician or a certified nurse practitioner.

The minor named in this consent form may receive all treatment provided according to generally accepted standards of medical practice with the following limitations (if none, write "NONE"):

____

My consent is effective for the following time period: From ______________to______________

☐ Yes, I consent for evaluation and treatment recommendations

☐ Yes, I consent for medications to be prescribed

☐ No, please do not give prescription medications if I am not present. (Please note if there are any questions regarding medication recommendations, a follow-up appointment will be necessary to discuss in further detail—**with parent present**).

Printed Name of Parent/Legal Guardian: _____________________________________

Signature of Parent/Legal Guardian: ____

PLEASE NOTE: PER OUR FINANCIAL POLICY ALL FEES ARE DUE AT TIME OF SERVICE. PLEASE PROVIDE YOUR CHILD WITH PAYMENT. FOR YOUR CONVENIENCE WE CAN KEEP A COPY OF YOUR CREDIT CARD IN OUR BILLING OFFICE'S SAFE IF YOU SO CHOOSE.