eastbaypediatrics
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Consent to treat a minor

By signing this consent, I authorize East Bay Pediatrics to provide medical services without my presence to the following minor patient(s):

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

The following is a list of names of the people and their relationship to the patient that I have given permission to bring my child/children to the medical office in my absence:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This consent pertains only to the minors listed above. Each person who will bring the child/children to the medical office is required to bring picture ID for identification verification.

I understand that I am accepting financial responsibility for all medical services rendered for the patient(s) and that payment is due at the time of service. I have the right to revoke this consent in writing.

Signature:_____ Date signed:_____

Printed Name: _____ Relationship: _____

Emergency Treatment Clause

In the event that during our absence at any time, any illness or accident should happen to our child, which in your opinion shall necessitate radiology or laboratory studies, a minor surgical operation, the giving of anesthetic, or any other medical treatment, we hereby consent to the physicians at East Bay Pediatrics performing or ordering such procedures or designating a physician to do so. East Bay Pediatrics is authorized to call an ambulance if necessary. If hospitalization is necessary, please take the child to UCSF Benioff Children's Hospital Oakland.

We would, of course, expect that you would communicate with us in the event of any serious accident or illness if practicable to do so, and that you would act under this consent only in an emergency, but at the same time, we want to make it clear that you are to be the sole judge of the practicability of communication, or the existence of an emergency and of the necessity of an operation or operations, or other treatment.

I understand that I am accepting financial responsibility for all medical services rendered for the patient(s) and that for all services not paid by your insurance carrier within 10 days of receipt of notification from our office by letter or billing statement. I have the right to revoke this consent in writing.

Signature:_____ Date signed:_____

Printed Name: _____ Relationship: _____

Signature:_____ Date signed:_____

Printed Name: _____ Relationship: _____