



Permission to Treat a Minor without a Parent/Legal Guardian present

Independence Park Medical Services must receive permission from a child's parent or legal guardian *before* providing treatments for an injury or illness that is non-life threatening. This form gives us legal permission to treat your child in case you are not able to accompany him/her to the clinic for treatment. If the adult party accompanying your child (relative, nanny, friend, etc.) does not present this signed information, along with a form of identification, the clinic will attempt to contact you to request permission to treat your child.

Please Note:

- A parent/legal guardian must attend a minor's FIRST visit here at IPMS.
- Minors may not receive immunizations without a parent or legal guardian present.
- This "Permission to Treat a Minor" form is valid only for the dates listed below, with a maximum of ONE year.
- This "Permission to Treat a Minor" form allows IPMS to bill the insurance and/or the responsible party listed on the account for all charges in connection with the care and treatment rendered.
- In certain circumstances, in accordance with State and Federal laws, parent/guardian permission may not be needed for adolescents being seen for concerns of "heightened sensitivity" such as STD testing, family planning, mental health, etc.

PATIENT NAME: _____ PATIENT DOB: _____

Please complete the option below that best suits your request:

1. I grant _____ (an adult into whose care, the minor has been entrusted) to arrange for and authorize routine and emergency treatment at IPMS for the following dates: _____ (These dates indicate when this form is valid, maximum of ONE year).

2. We/I are authorizing the minor to seek and consent to treatment with no adult present. This authorization is for the following dates: _____ (Only valid for 1 date of service if not specified, maximum of ONE year.)

Please initial:

☐ We/I acknowledge that we are responsible for all reasonable charges in connection with the care and treatment rendered.

PLEASE SEND THE INSURANCE CARD AND CO-PAY (if applicable) TO THE APPOINTMENT.

In case of Emergency, I can be reached at:

Home Phone: _____ Work Phone: _____ Cell Phone: _____

PARENT/GAURDIAN Signature: _____ Date: _____

PARENT/GAURDIAN Printed Name: _____

Relation to patient (documentation may be requested): _____