Complete Family Foot Care

PREAUTHORIZATION TO TREAT MINORS CONSENT FORM

This form authorizes Complete Family Foot Care to provide medical care or treatment to a minor who is accompanied to an office visit by an adult who is *not* the minor's parent or legal guardian, ex: a babysitter. This form may also authorize Complete Family Foot Care to provide such care to a child aged sixteen to eighteen without an accompanying adult. Please review the authorization and complete if you wish to authorize such treatment.

AUTHORIZATION

I appoint_____, who is
(Name) (Address)

my child's_____as my proxy decision maker for consenting to
(Specify Nature of Relationship to Minor)

the delivery of medical care for my child, _____
(Name of Minor) (Minor's DOB)

in my absence.

*Routine medical care and interventions may include, but are not limited to: medical evaluation, physical exam, x-rays, blood draws, liquid nitrogen treatment, injections, minor suturing of lacerations, removal of simple cysts or foreign bodies, incision and drainage of abscesses and ingrown toenail removal.

LIMITATIONS

Identify any limitations on the kinds of medical services for which this authorization is given. If none, state "None."

_____

_____

FOR MINORS SIXTEEN (16) to EIGHTEEN (18) YEARS OF AGE

I give my permission for "routine" treatment to be administered without my presence, or the presence of another accompanying adult as deemed necessary by the physician.

_____**YES** _____**NO**

I understand that this consent may be revoked at any time in writing to Complete Family Foot Care.

CONTACT INFORMATION

If the nature of the medical care is not routine or considered urgent, please contact me (us) regarding the healthcare of my child at the following phone numbers:

Parent/Guardian Name: _____ Parent/Guardian Name: _____

Mobile Phone Number: _____ Mobile Phone Number:_____

Daytime Phone Number: _____ Daytime Phone Number: _____

I hereby indemnify and hold harmless Complete Family Foot Care, and all their officers, agents, employees, attorneys, directors, insurers, affiliates, subsidiaries, related corporations, successors, heirs and assigns from any and all liability for acting in reliance on this authorization. The individual appointed as proxy (listed above) is permitted to make decisions or consent to the care in my absence. I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization. This authorization is valid for one year (1) following the date signed below unless withdrawn in writing to Complete Family Foot Care. *Only one parent's signature is required.*

Signature(s) of parent(s) or legal guardian(s):

_____/_____ _____/ _____

Please print full name ***Relationship*** ***Please print full name*** ***Relationship***

_____/_____ _____/_____

Signature ***Date*** ***Signature*** ***Date***