

## Consent to Treatment

**Kids Choice Pediatrics will not** provide health care to minors without a parent/legal guardian, parent's written consent or contact from the parent/legal guardian giving said consent. I also understand that written authorization is required before allowing anyone other than parent/legal guardian to bring child to the office for treatment.

**\*Legal guardians should bring all related documents to prove guardianship, before patient can be seen.**

**\*Exceptions:**

Child abuse, Patient seeking counseling/family planning services, Treatment for drug/alcohol abuse, Treatment for STDs, Suicidal ideation, Immunization to prevent STDs (Hep B) and/or HPV. For questions regarding this, contact:

**Texas Department of Health, Adolescent Health Promo at 512-458-7111 Ext 2021.**

### **In an emergency a Grandparent, Sibling, Aunt or Uncle can consent to treatment.**

As the parent/legal guardian of the child designated as patient, I hereby authorize **Kids Choice Pediatrics** to provide medical treatment deemed necessary for the patient. I understand that no guarantees can be made as to the eventual outcome of medical treatment advised or performed.

I give consent to the following people to seek medical treatment for my child in my absence:

Ex: Grandparent, Sister, brother, aunt, uncle ( if none please leave blank)

Name \_\_\_\_\_ Relation \_\_\_\_\_ Tel \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_ Tel \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_ Tel \_\_\_\_\_

- Hearing and vision tests are recommended for ages 4, 5, 6, 8, 10, 12, 15 and 18 years. We will perform these procedures for said ages and if insurance does not cover them, you will be responsible for payment. You will be sent a statement for the charges. If you wish to decline these services, please let us know in advance.
- I understand that when my provider of choice has a full schedule, it is possible to be assigned to any of the other available providers for same day sick appointments.
- I have read and agree to the Treatment Consent Policies stated herein.

**Printed name of Parent/Guardian** \_\_\_\_\_

**Signature of Parent/Guardian** \_\_\_\_\_

**Date** \_\_\_\_\_