

## Consent for the Treatment of a Minor when a Parent is not Present

The Medical Professionals of Holtsclaw Medical Centre, LLC are committed to providing you with quality, cost-effective healthcare. In order for HMC to care for your child in your absence we need this form completed on and file.

1. I am the legal parent or guardian of the child listed below.
2. I assign my right to the adult listed below to bring my child to Holtsclaw Medical Centre to be treated. I am aware that HMC will not call to confirm that my child will be seen in the office prior to the visit nor will a follow up call be made to inform that a service was performed.
3. I as the legal guardian understand that I am fully responsible for any financial obligations that may arise from the office visit.
4. I agree to hold Holtsclaw Medical Centre and its providers and staff harmless for any issues that may arise from my decision to allow my child(ren) to be seen without me physically present in the office.
5. This agreement will remain in force until informed in writing. To cancel or change the information please submit a new form in writing.
6. This will stay in effect until our office receives written notification from to revoke this consent.

I HAVE READ AND UNDERSTAND THIS AGREEMENT.

X \_\_\_\_\_  
Signature of Parent/Legal Guardian      Date \_\_\_\_\_

\_\_\_\_\_  
Printed Name

Witnessed By:

X \_\_\_\_\_  
Signature of Parent/Legal Guardian      Date \_\_\_\_\_

\_\_\_\_\_  
Printed Name

### Child/Children Allowed to Be Seen

Name : \_\_\_\_\_ BIRTH DATE : \_\_\_\_\_

Name: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

### Assignment Privilege

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_