Primary Care Pediatrics
and Family Medicine

Consent to Treat

Patient's Name: ____ Date of Birth___/___/___
Last Name Middle Name First Name

Please sign one of the options below:

Option 1:
I authorize Dr. Shrestha or any Primary Care Pediatrics and Family Medicine, P.C. provider to provide medical care for my child. In the event that my child is brought to the clinic by anyone other than a legal guardian or me, I authorize that my child may be treated in my absence. I understand that I am responsible for settling any costs arising from this care provided in my absence.
The following person(s) have my permission to authorize medical care for my child and sign any necessary waivers on my behalf.

Name	Relationship

For patients 16 years and older ONLY:

The patient listed above may present and be treated unaccompanied by an adult. Yes/No

Signature: ____ Date ___/___/______ Relationship: ____

OPTION 2:
I authorize Dr. Shrestha or any Primary Care Pediatrics and Family Medicine, P.C. provider to provide medical care for my child. In the event that my child is brought to the clinic by anyone other than a legal guardian or me, I do not authorize that my child be treated in my absence. I understand that by signing below, my child will not be treated unless a parent or legal guardian is present.

Signature: ____Date ___/___/______
Relationship: ____