COASTAL CAROLINA FAMILY PRACTICE, PA

Permission to Treat Minor Patient (Without Parent/Legal Guardian Present)

Coastal Carolina Family Practice must receive permission, from a child's parent or legal guardian, prior to Providing treatment(s) for preventative care, injury or illness that is non-life threatening. This form provides the Legal permission to (depending on the minor's age) either treat without any adult present (Section A), or with a Designated adult present (Section B)

Patient's Name: _____

Patient's Date of Birth: _____ Today's Date: _____

Section A (ONLY for child at least 16, but not 18 years old)

Authorization to treat your minor child in case you or your designated representative are unable to Accompany your child to one of his/her visits: I, (print your name) _____ grant Coastal Carolina Family Practice, permission to assess and treat the aforementioned minor without an adult present. I also agree to be financially responsible for payment of all charges in connection with the care and treatment Rendered.

Section B (for child under 18 years old)

Delegation of authority for medical treatment of a minor child to the designated representative indicated Below: I, (print your name) _____ grant Coastal Carolina Family Practice permission to assess and treat the aforementioned minor in the presence of either of the following adults (you may choose more than one), who is authorized to approve treatment:

Name: _____ Relation to minor _____

Name: _____ Relation to minor _____

I also agree to be financially responsible for payment of all charges in connection with the care and Treatment rendered.

NOTE: A parent / legal guardian MUST be present for a minor patient's first visit with Coastal Carolina Family Practice.

This authorization is valid for:

- ☐ This visit only (date of appointment): _____
- ☐ Until otherwise revoked

Please Note: Insurance card(s) and co-pay amounts (if applicable) must be presented at each visit. All patient copays, co-insurances, and self-payments not paid at the time of service will have our standard $10.00 billing fee added to the charges for said visit.

Authorized by: _____ Date: _____

Parent or Legal Guardian

Emergency Contact Phone #1 _____

Emergency Contact Phone #2 _____