North Scottsdale Pediatric Associates, PC

Fax: 480-860-8498 (Main Office)
Fax: 480-425-8498 (North Office)

CONSENT TO TREAT (TODAY ONLY)

Date of Visit: _______________

☐ **Consent for patients being brought to the office by someone other than the parent or legal guardian:**

I, the parent or legal guardian of ________________________________ (name/date of birth) hereby give ______________________________ permission to bring my child to the office today for an examination.

Please be aware that immunizations and/or procedures cannot be performed without the parent or legal guardian's verbal consent.

I will be available to give verbal consent to the administration of immunizations and/or any procedures at the following phone number(s):

1. (______)_______________________
2. (______)_______________________

☐ **Consent for a patient who is 16 years of age or older and coming to the office alone:**

I, the parent or legal guardian of ______________________________ hereby give North Scottsdale Pediatric Associates permission to treat him/her without me being present.

Please be aware that for your child's safety we will not perform immunizations or procedures if there is not an adult accompanying the patient.

I will be available at the following phone number(s):

1. (______)_______________________
2. (______)_______________________

****Please note**** Payment of copays and deductibles is due at the time of the visit. Please make sure that the person bringing your child(ren) to the office is prepared to pay for today's visit.

Parent/Legal Guardian Signature: ____________________________________

Date: ____________________________________