



North Scottsdale Pediatric Associates, PC  
Fax: 480-860-8498 (Main Office)

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

As the parent or guardian of \_\_\_\_\_, I am granting permission for North Scottsdale Pediatric Associates 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 arrangements for your child(ren) to be prepared to pay for today's visit.

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Parent/Guardian Signature

Date

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Parent/Guardian Name (please print)

Date