Our Village Pediatrics, LLC 115 Academy Street, Suite 101 Canton, GA 30114
Dr. Stephanie Hassel McNeil

Consent to Treat a Minor

*Required for NON-Parent caregiver of minor children in the absence of a parent

COMPLETED FORM MUST BE SUBMITTED PRIOR TO APPOINTMENT VIA FAX: 470-401-1089 OR EMAIL: FRONTDESK@ourvillagepediatrics.com

Patient Name: _____ DOB: _____

When I/We, the undersigned parent or legal guardian of the patient listed above are not present, I/we authorize the following caregivers (MUST BE OVER THE AGE OF 18) the right to consent to treatment, necessary exam, medical diagnosis, immunizations, injections and/or treatments, medication administration, and all other recommendations or consultations as advised by the medical staff at Our Village Pediatrics.

Name: _____ Relation to patient:_____

Name: _____ Relation to patient:_____

Name: _____ Relation to patient:_____

I understand that despite this consent, Our Village Pediatrics reserves the right to deny this consent and require your presence for the patient's treatment or care.

I also understand that I am responsible for payment and charges not covered by insurance as a result of this consent.

All copays are due at the time of the appointment and will be the responsibility of the adult that is present with the patient.

Parent/Guardian Name: _____

Signature: _____Date:_____