

Pediatric Associates, Inc.

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CONSENT FOR OFFICE VISITS

It is best that children are brought to our office for each visit by a **parent or legal guardian**. However, there may be times when someone other than you takes care of your child. That person may be a babysitter, caregiver or family member. If your child must be seen at our office at these times a **signed consent form is needed to provide medical care**.

This consent form allows the person you choose to seek medical treatment for your child when you are unable to con with the child. **The person you name must be 18 years of age or older.**

NO IMMUNIZATION WILL BE GIVEN TO ANY PATIENT AGES 7 MONTHS THROUGH 18 YEARS WITHOUT A PARENT OR LEGAL GUARDIAN PRESENT.

HOW TO USE THIS CONSENT FORM

1. Complete the information below. **Use a separate form for each child.**
2. Sign and date the form, and have an adult witness your signature. The person who will accompany your child can be the witness of your signature
3. Give the completed form to the person you have chosen. Have the person bring the consent for to the appointment.
4. This Consent for Office Visits is good for one year. It is kept in the child's chart. A new form must be completed and signed every year, **There needs to be a different form for each person bringing the child.**
5. The person bringing the child will be expected to provide insurance cards and pay any copayment.

I, (parent or legal guardian) _____ cannot accompany my child, (child's name) _____ to Pediatric Associates. Therefore, I give permission to _____ to accompany my child during his/her visit.

- I also give permission for this person to seek medical treatment for my child if attempts to contact me are unsuccessful. This permission does not include procedures requiring informed consent (such as any type of surgery or spinal tap).
- If my child is having his/her annual physical, I understand that it will be necessary for me to return with my child to receive immunizations and that an additional charge will be incurred.

Date _____ Signature of parent/legal guardian _____

Phone number where you can be reached: _____

Signature of witness 18 years or older _____

I authorize Pediatric Associates to provide any medical treatment including medication, medical supplies and consultations deemed necessary according to their professional opinion. I understand I am financially responsible for any non covered services by my insurance plan. I also authorize my insurance benefits to be paid directly to Pediatric Associates and the release of any information requested by my insurance carrier pertinent to my medical claim.

Signature: _____ Date: _____

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