Parental Consent Unaccompanied Minors Form

I do hereby authorize Little Legends Pediatrics, LLC to render medical care to my dependent child, _____.

This authorization includes routine as well as established appointments. If a fee is charged for services, I assume full responsibility for payment.

I authorize my insurance benefits to be paid directly to the provider and authorize the provider or insurance company to release any information required for this claim.

Consent needed for each occurrence ☐ Yes ☐ No

Consent valid only for _____(specific visit reasons)

Consent valid until age 18 all injuries/illnesses ☐ Yes ☐ No

Consent valid through_____(end date)

_____
Patient Name (Printed)

_____
Patient Date of Birth

_____ _____
Parent (or legal guardian) Signature Date Signed

_____
If signed by a person other than patient, please provide printed name, reason, relationship to patient, description of their medical decision authority (any and all care, medications, vaccines, etc.)

Martie Gravitt, MD
169 W. High Street
Mt. Gilead, OH 43338
Ph: (419) 751-7050
Fax: (740) 513-4628

Patient Name:
Date of Birth:
MRN: