Unaccompanied Child Authorization (Ages 16-18 years)

Patient Name:_____ DOB:_____

Initial _____ My child may be seen by himself/herself by Valley of the Sun Pediatrics until this authorization is withdrawn in writing. I understand that my child is responsible for payment of my families account balance and any other balances due at the time of the visit. If payments are due and not paid the appointment may be cancelled.

Or

Initial _____ My child may NOT be seen by himself/herself by Valley of the Sun Pediatrics.

Or

Initial _____ My child may be seen by himself/herself by Valley of the Sun Pediatrics for date of service _____. I understand that my child is responsible for payment of my families account balance and any other balances due at the time of visit. If payments are due and not paid the appointment may be cancelled.

I am aware that the HPV immunization or antibiotic injections will not be administered if an adult is not accompanying the patient.

Parent or Guardian Name: _____

Parent or Guardian Signature: _____ Date:_____