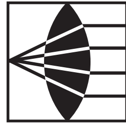

GRAND RAPIDS
OPHTHALMOLOGY

Eye Care | Surgery | Laser Correction

Permission to Treat Minor Patients

(17 years of age and younger)

This form may be used for established Grand Rapids Ophthalmology patients. *New* minor patients to the practice must be accompanied by a parent or legal guardian.

I, the undersigned ______ parent ______ legal guardian, do hereby give Grand Rapids Ophthalmology permission to treat ________________________________, for any vision or other problems related to his/her eyes using whatever ophthalmic treatments that Grand Rapids Ophthalmology deems necessary. This may include tests that are needed for the diagnosis of the condition for which the patient is being seen. This permission is valid for one year from this date, or until ____________________, __________, which date is less than 1 year from the date below.

Financial Responsibility

I shall be financially responsible for any charges related to this visit, and any subsequent visits, until the expiration date specified above. This will be accomplished by billing the insurance plan or responsible party (i.e. parent or legal guardian).

I further authorize the release of his/her medical record information for the purpose of obtaining payment or any further treatment necessary.

Print Name ____ Date ___________________________

Signature of Parent or Guardian ____

Relationship to Patient ____

____

Verbal Consent Given By: ______________________________________ Date: ________________________