Children's National

Pediatricians & Associates, LLC

Part of the Children's National Health System

Minor Consent

In order for us to treat a minor without a parent/legal guardian present, please complete this form and return it with a copy of the parent's/guardian's legal or photo identification to Children's Pediatricians & Associates.

I, _____, authorize Children's Pediatricians & Associates (CP&A) to provide medical care to my son/daughter, including, but not limited to, diagnostic examinations (including laboratory testing), treatment procedures, and prescribing of medications as deemed appropriate by his/her physician. I further understand that, once my child reaches the age of majority, my consent for treatment is no longer required. This consent will remain in effect until the patient reaches the age of 18 years unless revoked in writing to Children's Pediatricians & Associates.

Payment is expected the day of the appointment and can be made by cash, check, or credit card when checking in or in advance over the phone.

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

By signing below, I acknowledge I have read and agree to this consent and that any questions I had prior to signing were answered by CP&A.

_____ _____ _____

Parent/Guarantor's Signature **Print Name** **Date**

Office Use Only:

Intergy Pt Person # _____