

North Coast Family Medical Group, Inc.
Financial Responsibility and Consent to Treat a Minor

I, _____, legal guardian of _____,
Printed Name of Legal Guardian Printed Name of Minor Patient
authorize North Coast Family Medical Group to evaluate and treat him/her without my presence.

I understand that if it is medically inappropriate to treat the minor without a parent or guardian present, then the patient may need to be rescheduled regardless of this consent form.

I further agree that charges incurred regardless of insurance coverage are my responsibility and subject to insurance plan benefits and limitations.

This document is effective as of this date, _____, and will remain in
Date
effect until further notice or until the patient reaches eighteen years of age.

Legal Guardian Signature

Date

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