SPECIALIZED WOMEN'S HEALTHCARE, P.L.L.C.

Consent to Treat a Minor

I, _____, give Specialized Women's Healthcare
Parent / Guardian Printed Name

permission to evaluate, diagnose and treat as medically necessary _____.
Minor Patient's Printed Name

This consent is good for: _____ today's visit only
Initial

_____ the remainder of the current calendar year
Initial

***Right to Revoke: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this consent. I understand that prior actions taken in reliance to this consent will not be affected.

If there are any questions or concerns please feel free to contact me at:

Phone # _____

For all services rendered to minor patients, we will look to the parent or guardian with custody for payment. The parent or guardian of the minor patient is responsible for understanding his/her insurance benefits. Our office verifies the insurance benefits solely for our records and only as a courtesy to the patient.

Thank you,

_____ _____ _____
Patient (or Responsible Party's) Printed Name | Patient (or Responsible Party's) Signature | Date

_____
Patient's D.O.B.

_____ _____
Witness' Signature | Date