McCRIMMON PRIMARY CARE *plus*

Consent for Treatment of Un-emancipated Minor

For us to treat a minor without parental/legal guardian present, please complete this form and return it with a copy of the parent's/guardian's driver's license to one of the McCrimmon Primary Care Plus locations.

I, _____ (Print full name) am the parent/legal guardian of _____ (Print full name of patient) and _____ (Date of birth) who is currently a minor.

I authorize McCrimmon Primary Care Plus to provide medical care to my child, including, but not limited to:

- Diagnostic examinations (including laboratory testing, diagnostic imaging)
- Treatment procedures
- Prescribing medications as considered appropriate by their provider.

I understand that should my child need further invasive diagnostic or surgical procedures, attempts will be made to contact me, at the number I have provided below, before such care is initiated.

Primary Phone Number to Contact: _____

Primary Address of Parent/Legal Guardian: _____

By signing this form, I acknowledge that I have read and agreed to this consent and that any questions I had prior to signing were answered by McCrimmon Primary Care Plus.

Payment is expected on the date of service and can be made by cash or credit card when checking in or in advance via the patient portal.

_____ _____

Signature of Parent/Legal Guardian *Date*