Consent for Treatment of a Minor Patient

If a minor child (defined as anyone 17 years of age or younger) arrives for an appointment with someone other than a parent or legal guardian, South Michigan Ophthalmology (SMO) must have written consent from a parent or legal guardian that this person has been appointed by you to act on your behalf. We must also have written consent from a parent or legal guardian if your minor child (14 years of age or older) will be arriving unaccompanied. SMO will not see any minor children 13 years of age or younger without a parent, legal guardian, or an individual who has been appointed by you to act on your behalf.

This consent authorizes SMO to perform routine eye exams on your minor child which may include: refraction (measurement for glasses or contact lenses), tonometry (eye pressure test), and dilation to look inside the eye. If issues are found during the exam beyond the need for glasses or contact lenses, including anything medical or invasive, SMO may require further consent or the appointment to be rescheduled when the parent or legal guardian can be present and will attempt to contact you at the number provided below if necessary.

Minor's Name: ____ **Date of Birth:** __________________

Allergies: ____

Current Medications: ____

Chronic Conditions: ____

Limitations: Identify **any specific limitations** on authorized services for this consent (if none, state "none"):
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☐ Initial here if you wish to authorize another individual to accompany your minor child and to provide consent for routine eye exams (as listed above). Please list these individuals below:

Print Name: _______________________________________ **Relationship:** __________________________

Print Name: _______________________________________ **Relationship:** __________________________

☐ Initial here if you wish to give consent for your minor child to receive routine eye care (as listed above) without an accompanying adult, which shall be in effect for (choose one):

Date ______________ **ONLY** Date range: From ______________ through ______________

Indefinitely, until revoked by written communication

I may be reached at the following phone number during my child's appointment: ________________________

Authorization: I (parent/legal guardian name), ______________________________, request and authorize SMO and its personnel to perform routine eye exams on my child listed above. I am also aware that I am still financially responsible for all charges not covered by insurance including any co-pays due at the time of service. I understand that I may revoke this consent at any time in writing to SMO. By signing this, I acknowledge that I have read and understand this consent.

_______________________________________ _________________________________

Parent or Legal Guardian (please print) Relationship

_______________________________________ _________________________________

Parent or Legal Guardian Signature Date