ARBOR MEDICAL
PARTNERS

16+ Consent to Treat

Consent to treat a patient aged 16-17 years old in the office, without an accompanying adult

As the parent/legal guardian of _____, I am granting
(Patient's Name)
permission for Arbor Medical Partners to treat him/her without me being present.

PLEASE BE AWARE: For your child's safety we <u>will not</u> perform immunizations or procedures if there is not an authorized adult present during the office visit.

I, _____, can be reached at the following phone number(s):
(Parent/Legal Guardians Name)

1. (_____) _____ - _____
2. (_____) _____ - _____

PLEASE NOTE: Copays and deductibles are due at the time of check-in; please make sure you send your child with a credit card for payment.

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Parent/ Legal Guardian Printed Name Relation to the Patient