Avance Care®

Primary Care for Busy Lifestyles℠

Consent For Treatment of Un-emancipated Minor

In order 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 Avance Care, P.A.

I, _____ (print full name) am the parent/legal guardian of _____ (print full name of minor), who is currently a minor and whose date of birth is _____/_____/_____.

I authorize Avance Care, P.A. to provide medical care to my son/daughter, including, but not limited to: diagnostic examinations (including laboratory testing, diagnostic imaging), treatment procedures, and prescribing of medications as considered appropriate by his/her provider for the date of service _____/_____/_____.

I understand, that should my minor 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.

Best Phone Number(s) to Contact Me:
(_____) _____ - _____ (Home/Cell)
(_____) _____ - _____ (Work)

Address:
_____
_____
_____

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 Avance Care, P.A.

_____ _____/_____/_____
Signature of Parent/Legal Guardian Date Signed

Driver License State and Number: _____ _____

Payment is expected on the date of service and can be made by cash or credit card when checking in or in advance via phone. Please note, Avance Care, P.A. does not accept checks or American Express as forms of payment.