Piedmont Pediatrics
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Permission to Treat Without Parent/Guardian Accompanying Child

Piedmont Pediatrics must receive permission from a child's parent or legal guardian before providing treatment for an injury or illness that is non-life threatening. This form gives Piedmont Pediatrics legal permission to treat your child in case you cannot accompany your child to the office for treatment. If this information is not on file with us or presented by the party accompanying your child (baby-sitter, relative, friend), Piedmont Pediatrics will contact the child's parent or legal guardian before he or she is seen by the physician.

	Child's Full Name	**Date of Birth**
1)	_____	_____
2)	_____	_____
3)	_____	_____
4)	_____	_____
5)	_____	_____

Insurance co-pays and self pay charges are required at the time of service. There is a $10 service charge to bill a guarantor for a co-pay. Piedmont Pediatrics accepts cash, check, money order, Visa, MasterCard, Discover and American Express. If your check is returned to us by the bank, there will be a $35 return check fee added to your account. Also, we charge $25 when a patient does not arrive to a scheduled appointment, so we encourage you to call to cancel appointments in advance. Please see our full financial policy for further information.

Consent by Proxy for Non-Urgent Pediatric Care

I give Consent by Proxy to:

1. _____
Name ***Phone Number*** ***Relationship to Child***

as my proxy decision maker for consenting to non-urgent medical care for my child(ren) listed above. I have the legal right to delegate such consent to the proxy decision maker, who is an adult and legally and medically competent to exercise the authority so delegated. Be advised that protected patient health information may be shared with the proxy to whom the right to consent has been delegated to facilitate informed decision making.

I also give **Consent by Proxy** to:

2._____
Name ***Phone Number*** ***Relationship to Child***

3._____
Name ***Phone Number*** ***Relationship to Child***

4._____
Name ***Phone Number*** ***Relationship to Child***

Continued on Reverse

PIEDMONT PEDIATRICS
Permission to Treat Without Parent/Guardian Accompanying Child (cont.)

LIMITATIONS: Identify any limitations on medical services for which this authorization is given.
If none, state none.

_____

_____

_____

Specify the time frame for which the authorization is given. **If none, state none.**

Dates_____ to _____

If the nature of the medical care is not routine, please try to contact me regarding the health care of my child at the following phone numbers. If you are unable to contact me, you may rely on the proxy decision maker for the consent.

Name_____ Relationship to Child: _____

Day Phone_____Cell Phone_____ Evening Phone_____

Signature X _____ Date_____

Name_____ Relationship to Child: _____

Day Phone_____Cell Phone_____ Evening Phone_____

Signature X _____ Date_____