Premier Care Pediatrics
Where your family comes first

926 13th Ave S, ♥ Great Falls, MT 59405
Phone (406) 770-3000 ♥ Fax (406) 770-3146
Hours: Monday-Thursday 8am-5pm

PERMISSION TO TREAT A MINOR

We understand that work and other life circumstances may occasionally prevent a parent from coming to an appointment with a child who is under the age of eighteen. We work hard to balance patient needs and our medical responsibility in order to ensure optimal and collaborative health care for our patients who are becoming young adults. Parent must be available should they need to be contacted by phone during the exam by the provider. If written permission cannot be obtained before appointment time, verbal authorization will be allowed but written permission must be received within 24 hours of appointment time.

Exceptions to this include visits regarding **behavioral health** or **medication** follow-ups in which the parent must be present.

I _____ give permission for my child _____
(Name of parent/guarantor) (Name of minor child)

to attend his/her appointment alone on _____ without my presence and authorize treatment for my child
(Date of appointment)
in accordance with the office policy of minor children for Premier Care Pediatrics. This includes providing a history of present illness, disclosure of protected health information, and responsibility for relaying any diagnosis, treatment plan, or prescription(s) to the parent or legal guardian mentioned above. I understand that I am still responsible financially for all copays that are due at time of service.

In the case that immunizations/vaccines are needed at the time of appointment, I consent to my child receiving the vaccines listed below:

_____

Parents/Guarantor Contact Information During Appointment:
Where/how can you be contacted in case of emergency? _____
Phone: _____
Comments: _____

_____

Printed Name Parent/Guarantor: _____

Signature Parent/Guarantor: _____ **Date:** _____