DRIPPING SPRINGS PEDIATRICS

331 Sportsplex Dr. STE C Dripping Springs, TX 78620
Ph: 512-894-3737 fax: 512-894-3738
KATHLEEN STINSON, MD FAAP SHEILA BOES, MD ANNESSA VAN DE WALLE, FNP

PATIENT CONSENT FOR TREATMENT ACCOMPANIED BY NON-PARENTAL ADULT

PATIENT NAME: _____ DOB: _____

PARENT (GUARDIAN) NAME: _____ PHONE #: _____

I HEREBY AUTHORIZE _____ _____
(NAME) *(RELATION TO CHILD)*

- TO BRING MY CHILD TO HIS/HER APPOINTMENT(S) AND I GIVE THEM FULL CONSENT TO AUTHORIZE ANY TREATMENT ADVISED BY THE PHYSICIANS, PRACTITIONERS, AND STAFF OF DRIPPING SPRINGS PEDIATRICS.
- I UNDERSTAND THAT ANY MEDICAL ADVICE WILL BE RELAYED TO THEM ON MY BEHALF.
- I UNDERSTAND THAT IMMUNIZATIONS MAY BE DISCUSSED BUT WILL NOT BE ADMINISTERED. A VISIT WILL BE SCHEDULED FOR A TIME WHEN A PARENT WILL BE PRESENT.
- I UNDERSTAND THAT CHILDREN 14YR OR YOUNGER SHOULD BE ACCOMPANIED BY A PARENT FOR WELL MEDICAL CHECK UPS (MEDICAID IT IS REQUIRED).
- I UNDERSTAND THAT ANY CO-PAY OR CHARGES ARE DUE & I AGREE TO HAVE THEM PAID AT THE TIME OF SERVCE.

THIS CONSENT IS AUTHORIZED FOR: □ THIS DATE ONLY _____
□ BEGINNING TODAY _____
& ENDING UPON WRITTEN NOTIFICATION

□ WELL VISIT / SPORTS PHYSICAL
□ SICK VISIT

_____
(PRINTED NAME)

_____ _____
(SIGNATURE) *(DATE)*