



DRIPPING SPRINGS PEDIATRICS

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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 SERVICE.

THIS CONSENT IS AUTHORIZED FOR:

THIS DATE ONLY _____

BEGINNING TODAY _____

& ENDING UPON WRITTEN NOTIFICATION

WELL VISIT / SPORTS PHYSICAL

SICK VISIT

(PRINTED NAME)

(SIGNATURE)

(DATE)