Desert Canyon Pediatrics P.C.

Phone: 602-923-7730
Fax:602-923-7833

☐ **Consent for patients being brought to the office by someone other than the parent or legal guardian:**

CONSENT TO TREAT

☐ **Today only**

Name: _____ **Relationship to patient** _____

Name: _____ **Relationship to patient** _____

Name: _____ **Relationship to patient** _____

☐ **Recurring**

Name: _____ **Relationship to patient** _____

Name: _____ **Relationship to patient** _____

Name: _____ **Relationship to patient** _____

Please be aware that immunizations and / or procedures cannot be performed With out the parent or legal guardian's verbal consent.

I, the parent or legal guardian of _____ (name/date of birth) hereby give _____ permission to bring my child to the office today for an examination.

☐ **Consent for a patient who is 16 years of age or older and coming to the office alone:**

Please be aware that for your child's safety we will not administor immunizations or perform any procedures if there is not an adult accompanying the patient.

I, the parent or legal guardian of _____
hereby give Desert Canyon Pediatrics permission to treat him/ her without me being present.

I will be available to give verbal consent to the administration of immunizations and/or any procedures at the following phone number(s):

1.( ) _____
2. ( ) _____

**** Please Note ** Payment of copays and deductibles is due at the time of the visit. Please make sure that the person bringing your child(ren) to the office is prepared to pay for today's visit.**

Parent/Legal Guardian Signature: _____

Date: _____