



Consent for Minor Treatment When Parent or Legal Guardian Not Present

It is best that minors are brought for treatment by a parent or legal guardian. However, there may be times when the parent or legal guardian cannot bring the minor. This form allows the minor to receive treatment without the parent or legal guardian present.

Please note that anyone not listed as the insurance policy holder cannot sign any financial paperwork and this must be completed prior to initial appointment or the appointment will be rescheduled. This can be completed via our website www.fairfieldmedical.com and returned via mail, fax, or brought in at time of the appointment. If mailing or faxing documents please call prior to the appointment to verify the information was received.

How to use this form:

1. Make several copies of this form.
2. Complete all of the information on page 2 of this form. Use a separate form for each patient.
3. Sign and date the form and have an adult witness your signature.
4. Give the completed form to the patient (minor) and have the patient bring this form to Fairfield Medical Associates.
5. This form is kept in the patient's chart.
6. By checking the appropriate box below, you can choose to have this form be valid until you revoke it or only during a designated time period.
7. If you have a need to revoke this form, please complete the information required on page 3.
8. Be sure to tell the patient to get the doctor's and assistant's instructions in writing before leaving Fairfield Medical Associates. If you have questions about the instructions, be sure to call the office and speak with the physician's medical assistant.
9. The address to mail paperwork is Fairfield Medical Associates, 1781 Countryside Drive, Lancaster, Ohio 43130. The fax number for Fairfield Medical Associates is 740-475-0598 and the office number is 740-687-8600.
10. **All copays must be paid at the time of the appointment. If the copay cannot be paid at the time of the visit the appointment will be rescheduled.**

I, (parent/legal guardian) _____, cannot accompany
(patient's name) _____, to Fairfield Medical Associates.
Therefore, I give permission for (patient's
name) _____ as follows (check one):

- I give consent for this minor to receive treatment (including any kind of procedure, immunizations, testing, etc.) if attempts to contact me are unsuccessful.
- I give permission for this minor to receive treatment (Including any kind of procedure, immunizations, testing, etc.) without having to contact me.

Expiration of Permission (check one)

- This form will remain in effect until revoked by filling out the form on page 3.
- This form is VALID ONLY during the following timeframe:

Effective date: _____ /Expiration date: _____

X _____
(Signature of parent or legal guardian) (Date and time signed-required)

X _____
(Signature of witness-18 years of age or older) (Date and time signed-required)

Address _____

Home Phone _____ Work Phone _____

NOTICE TO REVOKE “DESIGNATION OF ANOTHER PERSON TO CONSENT FOR TREATMENT” FORM

I, (parent/legal guardian) _____, am the parent or legal guardian of (patient’s name) _____. Please immediately revoke prior permission for (patient’s name) _____ to consent for treatment.

X _____
(Signature of parent or legal guardian) (Date and time signed-required)

X _____
(Signature of witness-18 years of age or older) (Date and time signed-required)

Address _____

Home Phone _____ Work Phone _____

In order to process your Notice to Revoke, please bring this form with you to your next visit or fax it to our office at 740-475-0598.

OFFICE USE ONLY

Revoked by (staff name): _____

Date: _____