



## CONSENT TO TREAT

I, \_\_\_\_\_, give my permission to \_\_\_\_\_

to have my child or children, \_\_\_\_\_,  
treated by the physicians of Pediatric Associates P.S.C.

I can be reached at the following phone number if the doctors need to talk with me:

\_\_\_\_\_

With the use of HMO, PPO, and prepaid health care plans, most children have individual cards showing eligibility. These cards may need to be shown at each visit. Therefore, it is a good idea to leave your health plan cards with the person who will be bringing the child and make that person aware of co-pays. It is also a good idea for the person bringing the child to the office to bring some means of identification with them.

\_\_\_\_\_  
Signature of parent or legal guardian

\_\_\_\_\_  
Date