Physicians & Surgeons for Women

David R. Billing, M.D. Lisa M. DeLong, M.D. Angela R. Jackson, M.D.

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CONSENT TO TREAT A MINOR:

The information I have provided this office is complete and true to the best of my knowledge.
I authorize the physician and staff of Physicians & Surgeons for Women, to administer such procedures & treatment to _____ (minor) as deemed necessary.
I certify that I have authority and responsibility to authorize treatment for this child and **I understand and accept full responsibility for any balance, after insurance processing.**

INFORMED CONSENT :

I understand that there are certain risks associated with any form of healthcare treatment. I accept that risk in order that she may receive treatment by the Doctor and Staff of Physicians & Surgeons for Women, Inc., and agree to hold them harmless of any consequences thereof.

Please Print

Patient Name _____D.O.B. _____

I am the _____ Natural Parent _____ Legal Guardian _____ Conservator _____ Other

Consenting Adult Signature: _____

Printed Name: _____D.O.B. _____

SS# _____Date: _____

Witnessed by: _____Date: _____

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