ACCESS EYE
STAY FOCUSED

Consent to Treat Minor

Name of Minor: _____

Age: _____ Birthdate: _____

Address: _____

I, the undersigned, am the parent or legal guardian of the above-named minor. I hereby authorize Access Eye Centers, P.C. and its personnel (collectively, "Access Eye") to deliver routine eye examinations and care to my child/ward listed above as may be deemed necessary or advisable in the diagnosis and treatment of my child/ward. I understand and acknowledge that this may include eye examinations, tests required to diagnose certain eye conditions, dilation of the eyes, contact lens fittings, issuing prescriptions for eyeglasses and/or contact lenses, and other routine examinations and care.

I do hereby consent that Access Eye may administer the aforementioned examinations, treatment, and care to my child/ward **in my absence and without the presence of another adult** if my child is 16 years old or older.

In the event my child is under the age of 16, I understand and agree that he/she may not receive treatment unless an authorized adult (18 years or older) is present for the treatment. I hereby authorize the following adult(s) to be present for my child's treatment:

_____

and acknowledge that I am still financially responsible for all medical expenses incurred by my child/ward during these unaccompanied appointments.

By signing below, I acknowledge that I have read, understand, and give my consent as stipulated above.

_____

Parent or Legal Guardian (please print) Relationship

_____

Parent or Legal Guardian Signature Date