NORTH SCOTTSDALE
PEDIATRICS
A Division of Arbor Medical Partners

16+ consent to treat

Fax: 480-860-8498

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

As the parent or guardian of _____, I am granting permission for North Scottsdale Pediatric Associates to treat him/her without me being present.

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

I will be available 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 arrangements for your child(ren) to be prepared to pay for today's visit.

_____

Parent/Guardian Signature Date

_____

Parent/Guardian Name (please print) Date