St. Louis Pediatric Associates, Inc.
226 S. Woods Mill Rd. 32W ✦ Chesterfield, MO 63017
Phone (314) 576-1616 ✦ *Fax* (314) 576-5271

16-17 year Consent To Treat

Date: ___________________

I, ____, am the parent/guardian of ____ (print name of patient). I have the right to consent to medical treatment for this patient. I have given this child consent to drive to your office in my absence.

I voluntarily authorize and consent to the medical care, diagnostic testing, and treatment that Dr. ____________________________________ and his/her designated associates or assistants deem necessary for this child. I must complete and sign a separate vaccine consent form if vaccines are needed. I understand that by signing this form, I am giving permission to the doctors and staff at St. Louis Pediatric Associates, Inc. to provide medical treatment to this patient.

I acknowledge that this document is valid for:

_____specific date of service listed________________________
_____one month from date on form
_____one year from date on form
_____as long as my child is a patient in this practice

and is binding only if this child remains an established patient in the practice. **I agree that I am financially responsible for any services provided that are not covered by my insurance company.** I understand that I have the right to withdraw my consent at any time.

Parent/Guardian Signature: ____

Phone Number: ____