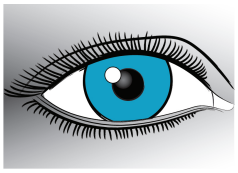

Eye Surgeons Associates

Medical • Surgical • Optical

Providing Your Best Vision For Life

CONSENT TO PROVIDE MEDICAL CARE TO A CHILD

PATIENT NAME_____ **AGE**_____ **DOB**_____

APPOINTMENT DATE / TIME_____

We request a parent or guardian accompany any child to their appointment. If you are unable to come to the clinic with your child, please select and complete the appropriate option below and have them bring this form to their appointment with their **most current medical and / or vision insurance card.**

We require all applicable co-payments be collected at check in. Contact lens fittings and any other balances will be collected at check out. Optical material purchases for eyeglasses and contact lenses must be paid at the time of order.

DO NOT MAIL THIS AUTHORIZATION

CONSENT VALID FOR THIS APPOINTMENT ONLY

[ ] CHILD IS AGE 16 OR OLDER I am sending my child without a parent or guardian and I authorize the doctor to take a history, perform an eye examination, and perform diagnostic testing if medically indicated. If treatment is needed the doctor will attempt to reach a parent or guardian as listed below by phone. I understand applicable co-payments will be required and collected at check in. Contact lens fittings and any other balances will be collected at check out. Optical material purchases for eyeglasses and contact lenses must be paid at the time of order.

_____ _____

Signature of parent/guardian Date Contact phone number

[ ] CHILD IS AGE 15 OR YOUNGER I authorize the doctor to take a history, perform and eye examination, and perform diagnostic testing if medically indicated. If treatment is needed I hereby appoint _____ as my representative. I empower him/her to act as legal guardian of medical care and diagnostic testing provided for my child during this appointment. I understand applicable co-payments will be required and collected at check in. Contact lens fittings and any other balances will be collected at check out. Optical material purchases for eyeglasses and contact lenses must be paid at the time of order.

_____ _____

Signature of parent/guardian Date Contact phone number

If you have any questions, please contact Eye Surgeons Associates, P.C.
Bettendorf: 563-323-2020 Rock Island: 309-793-2020
Geneseo: 309-944-8888

*MRN*_____