



www.cottonwoodpeds.com

Cottonwood Pediatrics
700 Medical Center Dr, Ste 150
Newton KS 67114
316-283-7100

Annual Consent to Treat
(Age 16 and older)

TO AVOID DELAYS IN TREATMENT
Please return this completed form by mail to the address above,
or by fax to 316-283-7118,
BEFORE the child's appointment

I/We, the undersigned parent(s) or legal guardian of the child listed below,

authorize: _____ Date of birth: _____
Name of child (who is age of 16 or older)

to consent to any X-ray examination, anesthetic, medical or surgical diagnosis, injections or treatment;
and/or hospital care to be provided to said child, when such services are recommended and supervised
by Cottonwood Pediatrics. I/We authorize Cottonwood Pediatrics to call in, at their discretion, any
necessary consultants.

I also understand that I am financially responsible for any co-pays and charges not covered by my
insurance which are incurred as a result of my child's consent to treatment.

This consent shall remain in effect for one year, unless it is revoked sooner in writing.

Father's signature AND/OR Mother's signature

Date OR Legal Guardian's signature

Parent/guardian's
home address: _____ Phone: _____

I agree to see to, and may consent to, my own medical care, as provided on this form.

I understand that I have the right to an explanation of any procedures and their risks, benefits,
alternatives, and charges before they occur. My signature here consents to these procedures; it is my
responsibility to inquire about and/or decline any such procedures. The occurrence of a procedure
indicates that I understand the risks and benefits and have received a satisfactory response to my
questions, if any.

Child's signature Date