



OPTIONAL - 16 and Older Consent to Treat

Cottonwood Pediatrics
700 Medical Center Dr.
Ste 150 Newton KS 67114
Phone: 316-283-7100
Fax: 316-283-7118

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

[Redacted area for parent/guardian name]

Date of Birth / /

NAME OF CHILD (WHO IS 16 YEARS OLD OR OLDER)

MM/DD/YYYY

to consent to any X-ray examination, anesthetic, medical or surgical diagnosis, immunizations, 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 authorized Cottonwood Pediatrics to call in, at their discretion, any necessary consultants.

I affirm that my child is mature and well-informed, having the intellectual capacity, experience and knowledge necessary to substantially understand the situation at hand and the consequences of the choices that can be made.

I understand that, despite this consent, Cottonwood Pediatrics, in its sole discretion, **may decide not to act on this consent**, and instead require my presence during my child treatment or care.

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 this consent for treatment and care.

Unless it is revoked sooner in writing, this consent remains in effect until

my child is 18 years old OR / / (MM/DD/YYYY)

Parent/guardian information

[Redacted area for parent/guardian name]

PARENT/GUARDIAN NAME

[Redacted area for phone number]

PHONE

 / /

TODAY'S DATE

[Redacted area for relationship to patient]

RELATIONSHIP TO PATIENT

PARENT/GUARDIAN SIGNATURE

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.

 / /

TODAY'S DATE

Signature of patient

Please fill and sign form BEFORE your child's appointment to avoid delays in treatment.

Copy of insurance card(s) and copay are due **at the time of service.**

Upload signed form at cottonwoodpeds.com/upload