

Treatment to Minors

Many times parents find themselves unable to accompany their teen or young adult children to appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child.

I hereby grant Dr. Debra Babich and/or her staff permission to treat my child when he/she arrives at the office unaccompanied.

Signature of Parent

Date

Authorization To Charge Services To Major Credit Card

This agreement is required if you wish your unaccompanied child to be seen.

Initial the following statements:

_____ I understand that I am responsible for payment of my account at the time of service for deductibles, non-covered services, medically unnecessary services, co-payments and insurance balances, should primary insurance be with a company with which the physician(s) are contracted. If my insurance company is not the one with which the physician is contracted, I am responsible for the entire amount at the time of service.

_____ For whatever reason should my account fall into a 45 day or later (after date of service), I authorize this office to generate charges to my major credit card for that unpaid balance without further permission or notice.

_____ A receipt for charges will be mailed to my address.

Circle which card you are using: VISA Master Card American Express Discover

Credit Card#: _____

Expiration Date: _____

Name as it appears on the credit card: _____

Signature

Date