ABC Children's Eye Specialists

Brendan Cassidy, MD | Rasha Barham, MD | Emily Shortridge, MD | James Plotnik, MD
Nicholas Silvestros, OD | Julia Sewell, OD | Lois Filipelli, OD | Monica LaDouceur, OD
Sara Sillik, OD | Alexa Saul, OD | Jeanette Stromme, OD | Andrew Abela, OD
Christopher Johnson, OD | Julie McCutcheon, OD | Lotus Schifsky, OD | Heba Al-Baiaty, CO

Pediatric Ophthalmology and Strabismus

Consent to Treat

(For NON-PARENT caregivers of minor children when a parent is not present)

TO AVOID DELAYS IN TREATMENT

Please return this completed form by mail to
PO Box 97876, Phoenix, AZ. 85060
Email to supervisors@abckidseyes.com Or fax to 866-985-7247 **BEFORE** the child's appointment

_____ _____
(Child's name) (Date of birth)

When I/we, the undersigned parent(s) or legal guardian(s) of the child listed above, are not present, I/we authorize:

_____ who is _____
(Name of adult who is NON-Parent) (relationship)

to the child and a caregiver of this child, to consent to any medical examination, and/or treatment to the said child, when such services are recommended and supervised by ABC Children's Eye Specialists. I/we authorize ABC Children's Eye to call in, at their discretion, any necessary consultants.

I understand that, despite this consent, ABC Children's Eye Specialist, in its sole discretion, **may decide not to act on this consent**, and instead require my presence during my child's exam.

I also understand that **I am financially responsible for any co-pays and charges** which are incurred as a result of this consent for treatment.

Unless it is revoked sooner in writing, this consent remains in effect until my child is 18 years old on

_____
(Date of 18th birthday)

_____ and / or _____
(Father's signature or legal guardian) (Mother's signature or legal guardian)

Phone number: _____
I agree to see to, and may consent to, the above named child's medical care, as provided on this form.

Non-parent signature: _____ Date: _____