COLUMBUS OPHTHALMOLOGY ASSOCIATES, LLC

CONSENT FOR NON-EMERGENCY TREATMENT OF MINORS

Columbus Ophthalmology Associates, LLC strongly encourages that a parent or legal guardian accompany any minor children (17 years old or younger) to their medical appointments. In the event that a parent or legal guardian is unable to accompany his or her minor child to a medical appointment, the parent or legal guardian should either (1) sign this Consent for Non-Emergency Treatment of Minors and send it to the minor child's health care provider prior to the medical appointment or (2) give it to the minor child to present to the health care provider at the time of the medical appointment. In the event that a minor child presents for a non-urgent medical appointment without a parent or legal guardian or a signed consent, treatment will be denied.

Name of child ______________________________________ DOB ___________________________

Name of parent or legal guardian ____

If there is a need to reach me during my child's appointment to discuss further care or treatment, I may be reached at the following phone numbers.
Home: (   ) _____-__________ Work: (   ) _____-__________ Other: (   ) _____-__________

Medical Appointment
I consent to care and treatment at Columbus Ophthalmology Associates, LLC for my child related to his/her medical appointment on _____/_____/_____ for ____ Date (month/day/year) Reason for appointment

Series of Routine Appointments
I consent to care and treatment at Columbus Ophthalmology Associates, LLC for my child related to a series of routine appointments from _____/______/______ to _____/______/______ for ____ Date (month/day/year) Date (month/day/year) Reason for appointment

I understand that in case of a medical emergency involving my child, a reasonable effort will be made to contact me and secure my consent for needed medical services including surgical procedures. If I cannot be located within a reasonable time, however, I consent to any emergency surgery or other emergency medical treatment necessary for my child.

I agree to reimburse Columbus Ophthalmology Associates, LLC for the cost of rendering these services.

____ ______/______/______
Signature of parent or legal guardian Date (month/day/year)