OLDHAM COUNTY PEDIATRICS, PLLC

PERMISSION TO TREAT

_____

Patient's Full Name:_____

(Last) (First) (MI)

Date of Birth:_____ SS#:_____-_____-_____

Parent's name:_____

Address:_____

_____

_____

Phone #:_____

I hearby give permission for the following caregivers to bring my child for routine and emergency treatment by Oldham County Pediatrics, PLLC. I also give my permission for Oldham County Pediatrics, PLLC to discuss the care of my child with the individuals below. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. I have read and agree to follow Oldham County Pediatrics Vaccination Policy, and realize that a parent or legal guardian must be present for vaccinations to be given. I consent to routine treatment and procedures provided by Oldham County Pediatrics, and understand that no guarantee of result has been made.

Caregiver Name and relationship to patient:

1. _____
2. _____
3. _____

PERMISSION TO REPORT LAB RESULTS

I hearby give Oldham County Pediatrics, PLLC permission to report normal lab/X-ray results, or that a prescription is ready on my voice mail or answering machine when I am not available to take their call.

Home Phone #_____Cell Phone#_____

_____

Parents Signature Date