city of vision eye care
Dean S Reynolds, OD
Mario Andreatta, OD
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Tracy Ho, OD

4025 Jackie Road SE: Rio Rancho, New Mexico 87124
505.892.8411 cov@swcp.com

POLICY: CONSENT TO MEDICAL TREATMENT OF UNATTENDED MINORS

To Parents and Guardians of Minor Children:

The providers and staff of City of Vision Eye Care place great emphasis on the health and well-being of each and every patient in our clinic. We appreciate that you have entrusted us to provide health care services to your minor child and we look forward to working with you to ensure that your child receives the best health care possible.

As a general rule, **we require the consent of a parent or legal guardian in order to provide health care services to a minor child** (someone under the age of 18). With so many parents working outside the home or with other commitments, we realize that you may not be able to accompany your child on every visit to the clinic. If your minor child presents to the clinic unaccompanied, we will not be able to see the unaccompanied minor. If the minor presents in the company of an adult other than a parent or legal guardian, they must have documentation from the parent or legal guardian giving consent for treatment. If they do not have consent for treatment the appointment will be rescheduled.

In an effort to provide the care needed and avoid having to reschedule your child's appointment, we have developed a consent form that, once completed by a parent or legal guardian, will be placed in your child's medical record for use as necessary. This form will allow us to provide routine and medical treatment (**including eye dilation**) for your minor child when deemed necessary by qualified medical personnel. Adults, other than the parent or legal guardian who accompany a minor child to an appointment and are authorized by the Consent to Treat a Minor on record, will be asked to present photo ID upon checking the patient in for the appointment. This consent form will remain in effect until revoked in writing. You may request this form from any member of our clinic staff.

By law, minors have the right to consent to certain health care without a parent or guardian's consent. A minor may consent to medical if the minor is emancipated (legally independent) or married to someone at or above age 18 or in the event emergency care is necessary.

Rest assured that we would continue to provide health care services that are in the best interests of your minor child.

If you have questions regarding any of this information, please contact us before your child's appointment.

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Patient name: _____ Date of birth: ___ / ___ / ___

Patient name: _____ Date of birth: ___ / ___ / ___

Patient name: _____ Date of birth: ___ / ___ / ___

I, the undersigned, parent(s) or legal guardian of the above named patient, a minor, do hereby authorize the physicians at City of Vision Eye Care to act as agent(s) for the undersigned to consent to ocular examination, **dilation**, medical diagnosis and treatment or other medical care which is deemed advisable by, and is to be rendered under the general or special supervision of, the treating physician who is licensed to practice in the state of New Mexico, whether such diagnosis or treatment is rendered at the office of said physician. **I further acknowledge that I am responsible for any portion of charges that are not covered by the child's insurance.**

Consent to Treat a Minor Child accompanied by an adult other than the child's parent or legal guardian

I, the parent or legal guardian of the patient named above, do hereby authorize the physicians at City of Vision Eye Care to perform medical treatment as per the statements above when accompanied by either of the following named adult persons over the age of 18:

Adult's name: _____ Relationship to the child: _____
(Print Name) (Grandparent, Aunt, Uncle, Sister, Brother, Family Friend)

Adult's name: _____ Relationship to the child: _____
(Print Name) (Grandparent, Aunt, Uncle, Sister, Brother, Family Friend)

This authorization is valid: (select all that apply)

- ✓ For any and all medical procedures including instillation of eye drops for eye pressure **& dilation** (typically covered by insurance)
- ○ For Optomap Retinal Photography (typically not covered by insurance)
- ○ Contact lens evaluation, fitting, and prescription (typically not covered in full by insurance)

- ○ For Date of Service only ___ / ___ / ___
- ○ For 1 year following date signed or until revoked in writing

Parent or legal guardian: (Print Name) _____ Date: ___ / ___ / ___

Parent or legal guardian signature: _____