Medical Treatment Authorization and Consent Form

For Minors Treatment without parent/legal guardian present

PLEASE RETURN FORM BY FAX TO 810-695-8002

The following form is designed for those situations where minors are unaccompanied by either a parent or legal guardian. This "Medical Treatment Authorization and Consent Form" gives authority to a designated adult to arrange for medical care for a minor. This is extremely important, in that, medical care cannot be provided to a minor without approval by the parent or legal guardian, unless there is written consent authorizing an agent to give approval.

Minor Information

Last Name	First Name	Middle Initial	Date of Birth
Street Address	**City**	**State**	**Zip**

Parent or Guardian Information

Last Name		First Name	Middle Initial	Date of Birth
Street Address		**City**	**State**	**Zip**
Home Telephone #	**Cell Telephone #**	**Work Telephone #**	**Social Security #**	
Email Address (Receipts for payments will be emailed to this address only)				

Authorized Adult Accompanying Minor

The undersigned do hereby authorize this adult as agent for the undersigned to consent to any medical or diagnostic treatment for the above named minor which is deemed advisable by and to be rendered under the general supervision of any physician or nurse practitioner licensed to practice at Complete Care Center.

First Name	Last Name	Cell Telephone #

Please complete the information below:

I _____ authorize Complete Care Center to charge my account indicated below for payment of medical care received by the minor listed above for **date of service** _____.

Credit Card

☐ Visa ☐ MasterCard

☐ Amex ☐ Discover

Cardholder Name _____

Account Number _____

Exp. Date _____

CVV (3 digit number on back of card) _____

I agree to notify Complete Care Center in writing of any changes in my account information or termination of this authorization. Signer authorizes Complete Care Center to debit the account for all sums owing to Complete Care Center including any NSF, chargeback or correction of credit card failure fees ($25.00 per). I am responsible for full payment of "Time of Service" fees at the time of service. I also release Complete Care Center from any billing issues in the future with insurance companies or others concerning "TOS charges.

SIGNATURE _____ DATE _____

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