

Northern Virginia Ophthalmology Associates, P.C.  
Medical Treatment Authorization and Consent Form

Consent to treat minors unaccompanied by either a parent or legal guardian.

This "Medical Treatment Authorization and Consent Form" gives authority to a designated adult to oversee medical care for a minor unaccompanied by either a parent or legal guardian.

I, \_\_\_\_\_,  
(NAME OF PARENT OR LEGAL GUARDIAN)

hereby give my permission as parent/guardian for the minor child,

\_\_\_\_\_  
(NAME OF CHILD)

to receive treatment from Northern Virginia Ophthalmology Associates  
under the care of

\_\_\_\_\_  
(NAME OF DESIGNATED ADULT ACCOMPANYING CHILD)

I understand that, in my absence, the designated adult will be asked to update any demographic or insurance related information. I understand that Northern Virginia Ophthalmology Associates will submit any insurance claims using this information and I am financially responsible for any fees associated with denied claims based on this information.

I understand that, in my absence, the designated adult may be asked to make statements regarding my child's health history and symptoms associated with their visit. I understand Northern Virginia Ophthalmology Associates may tailor treatments to those responses.

I understand that, in my absence, the designated adult will make decisions regarding my child's care at Northern Virginia Ophthalmology and I will be responsible for all charges associated with those services.

\_\_\_\_\_  
SIGNATURE OF PARENT OR LEGAL GUARDIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
VERBAL AUTH RECEIVED BY: NAME AND INITIALS

\_\_\_\_\_  
DATE

**THIS AUTHORIZATION EXPIRES on DECEMBER 31<sup>st</sup> OF THE CURRENT YEAR UNLESS OTHERWISE STATED.**