

# Permission to Treat Minor Patient

(Without Parent/Legal Guardian Present)

Frederick Primary Care Associates, P.A. must receive permission from a child's parent or legal guardian prior to providing treatment(s) for preventative care, injury or illness that is non-life threatening except in the circumstances noted below. This form provides the legal permission to (depending on the minor's age) either treat without any adult present (Section A), or with a designated adult present (Section B).

Patient's Name: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**Section A (ONLY for child at least 16, but not 18 years old) – Authorization to treat your minor child in case you or your designated representative are unable to accompany your child to one of his/her visits:**

I, (print your name) \_\_\_\_\_ grant Frederick Primary Care Associates, P.A. permission to assess and treat the aforementioned minor without an adult present. I also agree to be financially responsible for payment of all charges in connection with the care and treatment rendered.

**Section B (for child under 18 years old) – Delegation of authority for medical treatment of a minor child to the designated representative indicated below:**

I, (print your name) \_\_\_\_\_ grant Frederick Primary Care Associates, P.A. permission to assess and treat the aforementioned minor in the presence of either of the following adults (you may choose more than one), who is authorized to approve treatment:

Name: \_\_\_\_\_ Relation to minor \_\_\_\_\_

Name: \_\_\_\_\_ Relation to minor \_\_\_\_\_

I also agree to be financially responsible for payment of all charges in connection with the care and treatment rendered.

**NOTE: A parent / legal guardian MUST be present for a minor patient's first visit with Frederick Primary Care Associates, P.A.**

This authorization is valid for:

- This visit only (date of appointment): \_\_\_\_\_
- Until otherwise revoked

Please Note: Insurance card(s) and co-pay amounts (if applicable) must be presented at each visit. All patient copays and self-payments not paid at the time of service will have our standard \$10.00 billing fee added to the charges for said visit.

Authorized by: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent or Legal Guardian

Emergency Contact Phone #1 \_\_\_\_\_

Emergency Contact Phone #2 \_\_\_\_\_

*NOTE: Article 20-102 and 20-104 of the Annotated Code of Maryland (State Law) allows for the following exceptions, where a minor has the same capacity as an adult to consent to medical treatment and records retention:*

- 1) Treatment for and/or advice about drug abuse, alcoholism, contraception, sexually transmitted diseases, HIV testing, or pregnancy other than sterilization.
- 2) Physical exam for and treatment of injuries and/or collection of evidence from an alleged rape or sexual offense.
- 3) Consultation, diagnosis, and treatment of a mental or emotional disorder or admission to a detention center.

**MINORS WHO ARE MARRIED, PARENTS, EMANCIPATED OR A MINOR LIVING APART NEED NOT COMPLETE THIS FORM.**