

NORTH RALEIGH PEDIATRIC GROUP, P.A.

R E. Frerichs, M.D.
Kunjan Shakya, MD
Pamela P Golden, DO
Chitrabharathi Chandrasekaran, MD

7205 Stonehenge Drive
Raleigh, NC 27613
(919) 848-2249
Fax (919) 848-8238

Consent for Patient Unaccompanied by an Adult

I, _____ of _____ County, North Carolina, am the custodial parent having legal custody of _____, a minor child, and age _____, born on _____.

I authorize North Raleigh Pediatric Group and its medical personnel to provide medical and/or surgical health care to my child, including, but not limited to, diagnostic examinations, and necessary medical treatment including surgical procedures.

Minors 16 or 17 years old MUST have a Parent/Legal Guardian present for the initial office visit or they will be asked to reschedule their appointment.

This authorization will be in effect until: _____. I further understand, once my child reaches the age of eighteen (18), my consent for treatment is no longer required.

Furthermore, I understand that it is the policy of this office that the child who is presenting for treatment is responsible for payment at the time services are rendered.

By signing here, I acknowledge that I have read and understand this consent.

Parent/Guardian Name

Signature

Date: _____



GROW WITH US
Infants, Children, and Adolescents