

# NORTH RALEIGH PEDIATRIC GROUP, P.A.

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## 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.

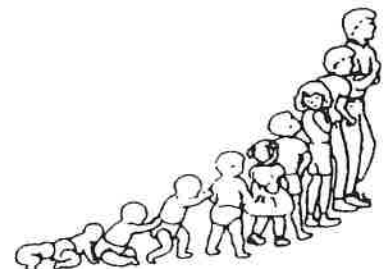
Furthermore, I understand that it is the policy of this office that the child who is presenting for treatment is responsible for payment at the time services are rendered.

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