Jeffrey A. Johnson, OD
Rebecca A. Schoepke, OD
Katherine S. Delgadillo, OD
Jacie M. Thomas, OD

CONSENT TO TREAT A MINOR

By law, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

Minor's Name: _____ DOB:_____

I authorize the following individual(s) to provide consent on my behalf:

Name: _____ Relationship to Patient:_____

Name: _____ Relationship to Patient:_____

I authorize Johnson Eye Care to perform medical care *without an accompanying adult:*

☐ Yes

☐ No

I authorize Johnson Eye Care Doctors to perform a retinal eye exam using:

☐ Optomap Retinal Photos ($36.00)

☐ Dilated Retinal Exam (Included in Exam)

This consent shall be in effect for:

☐ Indefinitely, until revoked by written communication.

☐ Date:_____ (only)

AUTHORIZATION: I (parent/legal guardian - printed name) _____ request and authorize Johnson Eye Care and its personnel to deliver routine medical care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. I am also aware that the adult presenting the child is responsible for payment of the patient portion at the time of service if applicable. I have the legal right to preauthorize Johnson Eye Care and its personnel to deliver routine medical treatment and services to my child. I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in a language that I understand.

Parent / Legal Guardian Signature: _____ Date: _____