BUCKS ENT ASSOCIATES

Adult & Pediatric Otolaryngology
ENT Allergy
Facial Plastic & Cosmetic Surgery
Head & Neck Surgery
Hearing Evaluation
Sinus Disorders
Sleep Apnea & Snoring Surgery

Benjamin S. Chack D.O.
John T. Gallagher M.D.
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CONSENT TO TREAT A MINOR 16-18

I _____give permission to my child _____to attend his/her illness appointment alone without my presence and authorize treatment for my child in accordance with the office policy of Bucks ENT Associates. This includes providing a history of present illness, disclosure of protected health information, and the responsibility for relaying any diagnosis, treatment plan, or presriptions to the parent or legal guardian mentioned above. I agree to be available by phone. I agree to be financially responsible for all copays and coinsurance. This authorization is effective on:_____ and expires _____.

Child's Health Information:
Current prescribed or over the counter medications:_____

Allergies, illnesses or other comments:_____
_____

Emergency contact information for Parents/Guardians:
Where/how can you be reached in case of an emergency?_____

Phone:_____Relationship:_____
Comments:_____

Health Insurance Information:

○ No change since last visit

Insurance Company:_____Policy Holder:_____

ID Number:_____Group Number:_____

Effective Date:_____Copay:_____

Parent or Legal Guardian's Signature:_____

Date:_____