James T. Hay, M.D.
Fellow, American Board of Family Medicine

Richard E. Payne, M.D.
Fellow, American Board of Family Medicine

Christine Clotfelter, D.O.
Diplomate, American Board of Family Medicine

Kelly Sales, PA-C
Physician Assistant, Certified

Chelsea Sapp, PA-C
Physician Assistant, Certified

North Coast Family Medical Group

Craig S. Duck, M.D.
Diplomate, American Board of Family Medicine

Susan M. Glockner, M.D.
Diplomate, American Board of Family Medicine

Amy Kakimoto, M.D.
Diplomate, American Board of Family Medicine

Lindsay Eggen, PA-C
Physician Assistant, Certified

Financial Responsibility and Consent to Treat a Minor

I, _____, legal guardian of _____,
Printed Name of Legal Guardian — Printed Name of Minor Patient

authorize North Coast Family Medical Group to evaluate and treat him/her without my presence.

I understand that if it is medically inappropriate to treat the minor without a parent or guardian present, then the patient may need to be rescheduled regardless of this consent form.

I further agree that charges incurred regardless of insurance coverage are my responsibility and subject to insurance plan benefits and limitations.

This document is effective as of this date, _____, and will remain in
Date
effect until further notice or until the patient reaches eighteen years of age.

_____ _____
Legal Guardian Signature — Date

_____
Relationship to Patient