

North Coast Family Medical Group, Inc.
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 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
Date
effective until further notice or until the patient reaches eighteen years of age.

Legal Guardian Signature

Date

North Coast Family Medical Group, Inc.
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 further agree that charges incurred regardless of insurance coverage are my
responsibility and subject to insurance plan benefits and limitations.

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Legal Guardian Signature

Date