RAINBOW PEDIATRIC CENTER

Authorized Consent to Seek Medical Care

□ I Do NOT authorize anyone other than the parents stated on the New Patient Questionnaire to seek medical care for my child.

_____ _____/_____/_____

Parent / Legal Guardian Signature Date

If you are allowing someone other than the parents to bring in the child, please complete and sign both boxes below

I (Parent / legal guardian), _____ am hereby giving permission for the following person to bring my child/children to Rainbow Pediatric Center and to receive medical treatment and advise during my absence.

Name:_____
Address:_____
City: _____ State:_____
Relationship to child: _____
DOB: _____/_____/_____

Please specify dates: From _____/_____/_____ to _____/_____/_____

Child/Children's Name	Date of Birth
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____

I also am providing my current insurance information along with my copayment or full payment for the services rendered. I also understand if Rainbow Pediatric Center is unable to obtain payment from my insurance company I am responsible for payment in full for services rendered to my child/children while under the care of the above named person.
**Copay must be paid by the authorized adult bringing the child in for services or a $5 fee will be charged.

_____ _____/_____/_____

Parent / Legal Guardian Signature Date