Women's Care Center of Columbus, Inc.

Consent to Treat Minor Child

I, ____, as parent or
NAME OR PARENT OR GUARDIAN
guardian for the patient____, do
NAME OF PATIENT
voluntarily consent to medical treatment by the provider, and her assistants, or her designee of Women's Care Center of Columbus, Inc. as necessary in her judgment. This consent includes routine, diagnostic procedures and medical treatment of conditions requiring medical care.

I am aware that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees have been made to me as to the results of treatment or examinations. I do acknowledge and consent to examination and treatment of my child by the provider(s) of Women's Care Center of Columbus, Inc.

I assign Women's Care Center of Columbus, Inc. all benefits payable under the medical expense provision of my insurance. If my insurance benefits do not cover the entire expenses, I will be responsible for payment of the difference. If my benefits to do not cover services provided, I will be responsible to Women's Care Center of Columbus, Inc. for the payment of the entire bill. I understand that I may receive separate bills from pathologists, labs or other entities for professional services provided.

I authorize Women's Care Center of Columbus, Inc., members of its staff, administrators, nurses and officials to furnish my health insurance company or its representatives any information pertaining to the routine care, illness or injuries sustained by my child and the treatment thereof for which she received medical care.

This authorization is effective from ____________________ to ____________________.

Parent or Legal Guardian (Print Name)____

Relationship to Patient: ☐ Mother ☐ Father ☐ Legal Guardian

Signature of Parent or Legal Guardian____

Telephone number where I can be reached:______________________Date________