



**Community**  
Physicians of Indiana

**Parent/Legal Guardian Authorization for Medical Care for Dependent**

Name of Dependent: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I (we) \_\_\_\_\_  
(name)

(and) \_\_\_\_\_  
(name)

authorize the following adult \_\_\_\_\_

to act in my/our behalf in seeking and authorizing medical care and in all respects act as the personal representative for health care for the above named dependent in my/our absence.

Please check the appropriate box below:

This authorization is to remain in effect until \_\_\_\_\_  
(date)

**OR**

This authorization is to remain in effect until revoke in writing by me/us

Parent/Legal Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Information and Consent  
Northside Family Care**

Name of Child: \_\_\_\_\_ DOB: \_\_\_\_\_  
Medications: \_\_\_\_\_  
Allergies: \_\_\_\_\_  
Medical History (surgeries, chronic problems, etc.): \_\_\_\_\_

**Mother or Guardian's Information**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_ (w)  
\_\_\_\_\_ (h) \_\_\_\_\_ (c)  
Employer: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Health Insurance: \_\_\_\_\_  
Policy #: \_\_\_\_\_  
Group #: \_\_\_\_\_  
Emergency Contact \_\_\_\_\_  
Phone: \_\_\_\_\_

**Father or Guardian's Information**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_ (w)  
\_\_\_\_\_ (h) \_\_\_\_\_ (c)  
Employer: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Health Insurance: \_\_\_\_\_  
Policy #: \_\_\_\_\_  
Group #: \_\_\_\_\_  
Emergency Contact \_\_\_\_\_  
Phone: \_\_\_\_\_

**Consent.** I hereby authorize such diagnostic and medical treatment of the above named child as may be considered necessary and appropriate by the treating practitioner. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees are being made to me or my child as to the result of any examinations, treatments or procedures performed.

**Signature of parent/guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Assignment of Benefits/Payment Agreement.** I assign to the above named practice or physician all medical and related benefits payable under my insurance policy so that they may be applied to my child's account. I understand that the above named practice or physician obtains verification of benefits and/or renders billing to insurance companies as a courtesy to me and that a verification of benefits is not a guarantee that the insurance company will pay those benefits. This assignment does not apply to patients with insurance that is not accepted by the practice or physician. I also agree that I am responsible for all charges for services rendered and agree to pay all accumulated charges not paid by insurance. I acknowledge that I will be responsible for all reasonable collection fees, including but not limited to attorneys' fees, court costs and interest, on all unpaid amounts.

**Signature of parent/guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

In the event I am unable to be with my child during a medical visit, I authorized the following person(s) to act as my child's personal representative in my absence: \_\_\_\_\_  
\_\_\_\_\_. I understand that this representation includes, but is not limited to, allowing the designated representative to schedule and cancel appointments, obtain medical advice from clinical staff, obtain my child's medical records, accompany my child to appointments, and signing consent for immunizations.

**Signature of parent/guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_