ALLIED PEDIATRICS

DELIA A WESSELS, MD, FAAP

add | 7405 Shallowford Rd Ste 270 Chattanooga, TN 37421-2662 web | www.MyAlliedPediatrics.com

| @MyAlliedPeds tel | 423-602-9545 fax | 423-602-9546 f | MyAlliedPediatrics

Treatment Authorization Limitations

Are there any considerations we need to know about that impact who may provide consent for treatment of the patient? (For example, does only one parent have custodial rights?) If so, please check this box and talk to our receptionist about these circumstances as we may need additional information from you.	☐
Additionally, are there special instructions or concerns we need to know about with respect to other family members or persons and care for or custody of the patient involved? If so, please check this box and discuss with our receptionist.	☐
Otherwise, check this box affirming that you have proper authority to consent to the provision of care to the minor patient identified and there are (i) no other considerations impacting same, and (ii) no special instructions concerning care for or custody of the patient.	☐

Authorization for Alternate Caretakers

Allied Pediatrics understands that special circumstances may arise. If for some reason you cannot bring your child to an appointment we allow up to 3 authorized caretakers to bring them in your place.

- I understand that alternate caretakers must have a valid ID that matches the information below or we will not be able to proceed with the appointment
- I understand that alternate caretakers will have the ability to make medical decisions regarding the patient at the appointment
- I understand that alternate caretakers will be responsible for making payments that are due on the day of the appointment
- I understand that alternate caretakers will have the ability to make financial decisions regarding the patient's account on the day of the appointment

Patient

Name: ______________________________ Date of Birth: ____________________

Caretaker 1

Name: ______________________________ Telephone #: ____________________

Relationship to Patient: ______________________

Caretaker 2

Name: ______________________________ Telephone #: ____________________

Relationship to Patient: ______________________

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Caretaker 3

Name: ____ Telephone #: ___________________________

Relationship to Patient: _______________________________

Parent/Guardian

Name: ____ Telephone #: ___________________________

Relationship to Patient: _______________________________ Signature: ______________________________