Lakeview Clinic Consent to Treatment of Minor

In presenting my son/daughter _____ for diagnosis and treatment at
(Child's Name & Date of Birth)
Lakeview Clinic, Ltd. I, _____ hereby voluntarily consent to the rendering of such care
☐ Mother ☐ Father ☐ Legal Guardian
including diagnostic procedures, medical treatment, and immunizations, by authorized, licensed members of the medical staff or their designees, that in their professional judgment, may be necessary. I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment during my child's appointment(s). I have read this form and certify that I understand its contents.

We/I hereby give our (my) consent to **Lakeview Clinic, Ltd**, who will be caring for our (my) child,

_____ initiating on _____ and continuing for
(Child's Name & Date of Birth) (Current Date)
one (1) calendar year. After one (1) calendar year from the aforementioned date of initiation, this form will expire and must be re-completed if the dependent child outlined in this form has not reached eighteen (18) years of age.

We/I acknowledge that we are (I am) responsible for all reasonable charges in connection with care and treatment rendered during this period.

Name: _____ Family physician: _____

Address: _____

_____

Telephone no.: _____

By signing below, I acknowledge that I have read this form in its entirety, understand the contents outlined above, and fully consent to Lakeview Clinic, Ltd. providing medical diagnosis, treatment, and procedures to my child outlined in this form.

_____ _____
Parent/Guardian Signature Date

_____ _____
Lakeview Clinic, Ltd. Representative Date