L.O. Eye Care
Permission to Treat

This form may be used for established L.O. Eye Care patients. New minor patients to the practice must be accompanied by a parent or legal guardian.

I, the undersigned ___ parent ___ legal guardian, do hereby give L.O. Eye Care permission to treat _____, my ___ child ___ ward, for any vision or other problems related to his/her eyes using whatever ophthalmic treatments that L.O. Eye Care deems medically necessary. This may include tests that are needed for the diagnosis of the condition for which the patient is being seen. This permission is valid for one year form this date, or until _____, ____, which date is less than one year from the date below.

Financial Responsibility

I shall be financially responsible for any charges related to this visit, and any subsequent visits, until the expiration date specified above. This will be accomplished by billing the insurance plan or responsible party (i.e. parent or legal guardian).

I further authorize the release of my ___ child's ___ ward's medical record information for purposes of obtaining payment or any further treatment necessary.

Print Name: _____ Date: _____

Signature of Parent or Guardian: _____