Pinnacle Peak Podiatry
7450 E Pinnacle Peak Rd, Ste 156
Scottsdale, AZ 85255
480-563-5115
Fax: 480-563-5132
Cathleen A McCarthy, DPM Kristina Jay, DPM

PERMISSION TO TREAT A MINOR

I _____ give permission to my child _____
(*Name of guardian)* (*Name of child age 16-18)*
to attend his/her podiatry appointment alone without my presence and authorize treatment for my child in accordance with the office policy of Pinnacle Peak Podiatry. This includes providing a history of present illness, disclosure of protected health information, and responsibility of relaying any diagnosis, treatment plan, or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone and to be financially responsible for all copays, deductibles and coinsurance. This authorization is effective on:
_____ and expires _____.
(Today's Date) (*Date Authorization is no longer valid)*

We will need a copy of the driver's license of the parent or guardian.

Child's Health Information:
Current prescribed or over-the-counter medications and dosages:
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____

Allergies, illnesses or other comments: _____
_____
_____

Emergency Contact Information for Parents/Guardians:
Where/how you can be contacted in case of emergency? _____
Phone: _____
Comments: _____
_____

Temporary Guardian Information:
Name: _____ Phone: _____
Address: _____

Health Insurance Information ☐ No Change since last visit (***skip to the next section***)
Insurance Company: _____ Policy Holder: _____
ID Number: _____ Group Number: _____
Effective Date: _____ Copay: _____

Parent or Legal Guardian's Signature: _____
Date: _____