MILLS eye care

CONSENT TO TREAT MINOR CHILDREN

Patient Name:_____ Patient Date of Birth: _____

I, _____, mother / father / legal guardian of _____, do hereby consent to any medical and routine vision care determined by Mills Eye Care to be necessary for the welfare of my child in my absence. I will not be present during the appointment and therefore give my consent for my child to be seen by Mills Eye Care. I also understand that I am responsible for payment of any services rendered during the visit.

ALLERGIES TO DRUGS OR FOOD: _____

_____

SPECIAL MEDICATIONS / OTHER PERTINENT INFORMATION: _____

_____

PLEASE COMPLETE THE FOLLOWING:

1. I give consent for this minor to have an Optomap / retinal image photos. I understand there is an out-of-pocket charge of $39 for this service.

   _____YES _____NO

2. I give consent for this minor to have a contact lens evaluation. The out-of-pocket charge for this service ranges from $60 to $150. If you have vision insurance, our staff can discuss your policy coverage to determine this cost prior to the appointment.

   _____YES _____NO

3. I give consent for this minor to be dilated. There is no out-of-pocket charge for dilation.

   _____YES _____NO

Printed Name of Legal Guardian: _____

Signature of Legal Guardian: _____Date:_____