Florida Medical Clinic
Your life. Our specialty.

Unaccompanied Minor Form

Authorization to Consent for Treatment of Minors

Minor Patient's Information			
Last Name		First Name	
Date of Birth		Account #	
Street Address			
City/State		Zip Code	

Florida Medical Clinic Department Authorized to Treat Minor			
I acknowledge this form only pertains to the department provider listed below. Should the minor seek care in other departments within Florida Medical Clinic, this form must be completed at that time.			
Provider's Name		Department	

Florida Medical Clinic will ONLY provide the following procedures or services to the minor:

☐ Evaluation and management (follow-up visit) ☐ Immunization/vaccine

☐ Other (specify):

Parent/Legal Guardian's Information			
Last Name		First Name	
Date of Birth		Relationship	
Driver's License #			
Phone #			

I authorize the following person(s) to consent to treatment for the above identified minor.
The person below MUST present identification at the time of the visit.

Name		Relationship	
Contact Information			
Name		Relationship	
Contact Information			

This form will expire on the following event: ☐ Minor's 18th birthday ☐ End of the calendar year

Authorization and Consent

I am the parent/legal guardian for the minor listed above who is under the age of 18 years old.
I understand the emergency contact that I listed above may be contacted in the event I am unavailable.
I understand that my insurance or existing payment method will be billed for the services rendered to the minor listed above.
I understand this authorization is valid until the 18th birthday of the patient, expiration date **OR** upon written revocation.
I understand this form does not release me (parent/guardian) from signing an informed consent as required by law. FMC will contact me and obtain my consent with informed consent is necessary.
I understand this form must be completed prior to the first unaccompanied visit at Florida Medical Clinic.
I have read and understand the contents of this form, which I voluntarily sign.

Parent/ Guardian Signature

Parent/Legal Guardian Signature		Date	
Print Name			

Emancipated Minor Options

☐ I authorize Florida Medical Clinic, LLC to bill my parent's/legal guardian's insurance for this visit

☐ I do not authorize Florida Medical Clinic, LLC to bill my parent's/legal guardian's insurance for this visit. I understand I will assume all financial responsibilities for this visit

Patient Signature		Date	
Print Name			