

210 Christiana Medical Center

Newark, DE 19702

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# Treatment Authorization

**Patient Name Birthdate**

I, (Parent/Guardian) hereby give my full permission and authorization to First State Pediatrics to see and treat my child medically. This permission/authorization shall be and remain in effect until cancelled in writing.

As the parent/legal guardian of (child), I hereby authorize the following person(s)

to accompany my child named above to office visits at First State Pediatrics, and to consent to the examination and/or treatment of my child during these office visits.

This authorization is effective until revoked by me in writing, and I reserve the right to revoke this authorization at any time.

Parent/Guardian Date

# Policy Regarding Missed Appointments

I am aware there will be a **$40** fee for missed appointments. Appointments may be cancelled with 24 hours advance notice.

Parent/Guardian Date

[*www.firststatepediatrics.com*](http://www.firststatepediatrics.com/)

Revised 8/01/2024