First Choice Medical Care, PLLC
1950 Cook St. Suite C & D
Dyersburg, TN 38024

CONSENT FORM

The undersigned consents to an examination (x-ray or otherwise), including but not limited to medication, lab procedures or any other treatment that may be deemed necessary by the attending physicians

I authorize First Choice Medical Care, PLLC providers to evaluate and treat my minor child _____, without the presence of a parent or legal guardian. I assume responsibility for charges incurred as a result of these services. I understand that my child will be required to show her/her insurance card and pay any applicable co-payments at the time of service.

Patient or Guardian signature for consent of treatment:

_____ Date: _____
Patient or Guardian signature

POWER OF ATTORNEY
&
LIVING WILL

I have received a copy of the information regarding Power of Attorney and Living Will. I do not have a Power of Attorney and Living Will on file. If I decide to use it, I will provide a copy.

Patients Signature: _____ Date: _____

Witness Signature: _____ Date: _____