



**OLDHAM COUNTY PEDIATRICS, PLLC**

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**PERMISSION TO TREAT**

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Patient's Full Name: \_\_\_\_\_  
(last) (first) (MI)

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Parent's name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone #: \_\_\_\_\_

I hereby give permission for the following caregivers to bring my child for routine and emergency treatment by Oldham County Pediatrics, PLLC. I also give my permission for Oldham County Pediatrics, PLLC to discuss the care of my child with the individuals below. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. I consent to routine procedures provided by Oldham County Pediatrics, PLLC, and understand that no guarantee of result has been made.

Caregiver Name and relationship to patient:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

\_\_\_\_\_  
Parents Signature

\_\_\_\_\_  
Date