Consent for Care

I, ______________________________ as parent and/or guardian of ________________________,

date of birth ___________________, do hereby consent to any routine vision and medical care determined by Lodestar Family Eye Care, PC to be necessary to the welfare of the above identified patient in my absence. I will not be present during the appointment and, therefore, give my consent for the above identified patient to be seen by Lodestar Family Eye Care, PC.

I understand that Lodestar Family Eye Care PC will act in the best interest of the above identified patient and may need to perform specialty testing and/or dilation in order to determine the most appropriate diagnosis and treatment plan.

I also understand that I am responsible for payment of any services rendered during the visit. Please refer to our Financial Policy for details on specific financial responsibilities.

____ ______________

Patient's Signature / Authorized Person to Sign for Patient Date

____ ______________

Doctor / Witness Signature Date