KJARTAN D. ARMANN, M.D.
Infant, Child and Adolescent Medicine

340 Dardanelli Lane, Suite 25A
Los Gatos, CA 95032
Phone: (408) 374-5440
Fax (408) 374-5468

Consent of Treatment

Patient Name: ____D.O.B. ______________________

CONSENT FOR TREATMENT OF A MINOR:
I authorize Kjartan D. Armann, M.D. to perform on my child any necessary or routine medical or surgical treatments, including examination, injections, immunizations, and/or laboratory analysis. I understand that in unusual circumstances efforts will be made to contact me prior to the rendering of treatment, but that medical treatment will not be withheld if I cannot be reached.

This authorization will remain in effect unless so designated in writing that such consent for treatment of a minor is rescinded.

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Parent's Initials

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize Kjartan D. Armann, M.D. to release any information acquired in the course of my child's examination or treatment to insurance companies or others as designated by me.

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Parent's Initials

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I hereby authorize payment directly to Kjartan D. Armann, M.D. for the surgical and/or medical services provided.

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Parent's Initials

ACKNOWLEDGEMENT OF MISSED APPOINTMENT POLICY:
I agree to cancel any scheduled appointment for my child that I do not plan to keep. I understand that failure to do so will result in an additional charge of $50.00. I understand that at least 24 hours prior notification is required.

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Parent's Initials

I have read, understood and agree to the above consent, authorizations and acknowledgement.

Signature: ____Date: _______________

Name: ____

□ Mother □ Father □ Legal Guardian