western michigan PEDIATRICS

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

I (parent/legal guardian) _____

authorize _____ to seek care for my minor child(ren) at Western Michigan Pediatrics. I am aware that I am responsible for payment of the patient portion such as copays, deductibles and co-insurance.

Permission is given for the following types of visits:

- ☐ Evaluation and treatment
- ☐ Well visits
- ☐ Recommended Immunizations
- ☐ Lab tests or x-rays

This Authorization is valid:

- ☐ **For this date only_____.**
- ☐ **Indefinitely, or until revoked by me.**

I may be reached at the following phone number:_____

Preferred Pharmacy _____

Signed: _____ Date:_____