Norwich Ophthalmology GROUP
You'll see the difference.

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Consent for Treatment of a Minor Patient

I, _____ , parent or legal guardian of

_____ , _____ give Norwich Ophthalmology
Child's name DOB

Group, P.C. permission to provide any medical and routine vision treatment necessary for the welfare of my child in the event that I do not accompany my child or am not present at the time services are rendered. I also understand that I am responsible for payment of any services rendered during the visit.

Please initial:

_____I give consent for this minor to have a contact lens evaluation and fitting ($100 due at time of service).

_____ I give consent for this minor to be dilated.

_____ _____
Parent or Guardian Signature Date

_____
Parent or Guardian Printed Name

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