Aurora Eye Clinic, Ltd.
1300 N. Highland Avenue
Aurora, Illinois 60506

# CONSENT FOR TREATMENT OF A MINOR

The following information is to be completed by the patient's legally authorized representative/parent:

I consent to medical treatment for the patient for whom I am the parent or legally authorized representative. I understand that Aurora Eye Clinic, Ltd. will share patient health information according to federal and state law for treatment, payment, and operations.

Describe medical procedure to be performed:

I understand that the patient is responsible for all charges incurred, regardless of the patient's insurance status. The patient agrees to pay for services as the patient incurs the charges. I authorize the insurance provider or other third party payer to pay Aurora Eye Clinic, Ltd. for medical services rendered and medical supplies provided and I hereby assign to Aurora Eye Clinic, Ltd. all of the patient's rights to payment for medical services rendered and medical supplies provided.

Date: _____

Name of Patient: _____

Signature of Legally Authorized Representative: _____
(Parent/Legal Guardian/Person having legal custody)

Relationship of Legally Authorized Representative to Patient:_____