



## Parental Permission Form for Minor Patient

Fax: 985-727-7375

Dear Parents and/or Guardians:

We are pleased to have your child as our patient. Our goal is to provide quality medical care at a fair and reasonable price, in a comfortable setting. Please call us if you have any concerns, questions or suggestions. Our receptionists will be happy to assist you.

We would like you to take a minute to fill out the permission slip below which will authorize Dr. Stewart or Dr. Gioe to provide health care for your child without your presence. Please have your child bring the permission slip to his/her visit, mail it to our office, fax it, or drop it by our office before your child's visit.

Thank you very much for your cooperation.

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### Permission Slip

By signing below, I authorize Dr. Martha E. Stewart or Dr. Olivia A. Gioe to provide for my child or legal dependent named below, such health care as they deem medically necessary or desirable. While such a procedure might be other than routine or customary, but is nonetheless deemed advisable by either Dr. Stewart or Dr. Gioe, I understand that they will, except for emergency cases, make efforts to get in touch with me and obtain my authorization. In case of emergency, I authorize Dr. Stewart or Dr. Gioe to act on behalf of my child or legal dependent in the way that they deem medically advisable.

I accept full financial responsibility and understand that payment is due for professional services at the time they are rendered.

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Print Child's Name

Signature of Parent/Guardian

Date

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Complete Address

Home Phone

Cell Phone