THE CHILDREN'S CLINIC
3 Fairwind Street
P.O. Box EE 17887
Nassau, Bahamas
Tel: (242) 323-0266 Fax: (242) 698-6703
Email: paedsclinic@yahoo.com

Name of Patient: _____

Date of Birth: _____

CONSENT FOR PATIENT TREATMENT

AUTHORIZATION

I hereby authorize the healthcare professionals at THE CHILDREN'S CLINIC to provide such medical care and to administer such treatment, including immunizations, as deemed necessary or advisable to the named patient each time he / she presents to THE CHILDREN'S CLINIC.

GUARANTOR OF ACCOUNT

I hereby agree to pay in full ALL charges to THE CHILDREN'S CLINIC at the time services are rendered. I also agree to pay any amount not covered by Primary or Secondary Insurance within 30 days of receipt of statement.

I confirm that I have read and understand the above statement

Parent / Relative or Guardian

_____

(Responsible for Account) (Signature)

_____

(Print Name)

_____

(Date)

P.O. Box _____

E-Mail: _____

Phone
(W)_____(H)_____(M)_____

Alternate Contact

_____

Witnessed by THE CHILDREN'S CLINIC
Administration_____