Coast OB-GYN
366 San Miguel Dr. #209
Newport Beach, CA 92660
Phone: 949-520-7078 Fax: 949-209 4177

PARENT **Date: _____**

Confidentiality Agreement

I allow my daughter to enter in a confidential patient-physician relationship. I understand that my daughter can make independent health care decisions, but that my input and involvement will be encouraged.

_____ My daughter has permission to schedule appointments and receive confidential reports from this office.
Intial

Treatment Agreement

As parent or legal guardian of the minor patient, I authorize Coast OB-GYN physicians and health care providers to render treatment and perform such procedures as the physician deems necessary for the treatment of my daughter.

_____ My daughter can receive treatment from Coast OB-GYN providers.
Intial

Financial Agreement

As parent or legal guardian of the minor patient, I agree to pay for all services rendered in accordance with the terms and conditions set forth in the financial policy of this office. In the event legal action should become necessary to enforce payment of any charges, I agree to be responsible for and will pay all reasonable attorney's fees, costs of collection and court costs where appropriate by law.

_____ I will take full financial responsibility for my daughter's care.
Intial

I have read and understand the above confidentiality agreement, the treatment agreement and the financial agreement.

Parent Signature _____

PATIENT

I am entering a confidential physician-patient relationship with my doctor. I will make an effort to communicate with my parent(s) about issues concerning my health. I accept the personal responsibility of being honest and will follow the health care recommendations my physician and I establish.

Patient Signature _____