DRS BEAMER, CARLON & CRAIGEN, S.C.
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CONSENT TO TREAT FOR UNACCOMPANIED TEENAGERS, AGES 15 TO 17

I, _____, have talked with my parent(s) and Dr. Beamer or Craigen, and they all agree that I will make appointments and be seen and treated by Dr. Beamer or Craigen without my parent(s) being present.

Dr. Beamer or Craigen has told me that these visits will be confidential and no information will be given to my parents unless authorized by me. The exception to this rule is that if Dr. Beamer or Craigen feels my health or life is in danger, then she may discuss my visit with my parents(s).

The signatures below indicate that we have read this and understand its contents.

_____	_____	___/___/___
Print name of patient	Signature	Date (Month/Day/Year)
_____	_____	___/___/___
Print name of parent	Signature	Date (Month/Day/Year)
_____	_____	___/___/___
Print name of witness	Signature	Date (Month/Day/Year)