Anita Sabeti, M.D. Pediatrician

Consent For Treatment - Please Sign

Patient's Name . . . . .DOB: . / . . ./ . .

I authorize Dr. Sabeti or covering doctor, to render any medical care to my child and bill insurance on my behalf.

Parent's Name:. . . . . .

Date: . . . . . .

Signature: . . . . . .

☐ I Authorize ☐ I **Do Not** Authorize

Dr. Sabeti or a covering doctor to render any medical care necessary to my child, If I am not available and no other legal guardian is available at the time my child is brought to the office.

Parent's Name:. . . . . .

Date: . . . . . .

Signature: . . . . . .