

Peter McKay, M.D.
Anish Shah, M.D.
Ron Slocumb, M.D.
Kinneri Kothari, M.D.
Michael Goldstein, O.D.
Rebecca Kivlin, O.D.
Jasmeet Aujla, O.D.
Renae Reynolds, O.D.

Consent for Treatment of a Minor Patient

I,	_ , parent or legal {	parent or legal guardian of	
 Child's name	, DOB	give Norwich Ophthalmology	
Group, P.C. permission to provide any medical and	d routine vision tr	eatment necessary for the welfare of my	
child in the event that I do not accompany my chil	ld or am not prese	ent at the time services are rendered. I als	
understand that I am responsible for payment of a	any services rende	ered during the visit.	
Please initial:I give consent for this minor to have a cor	ntact lens evaluati	ion and fitting (\$100 due at time of	
service) I give consent for this minor to be dilated	d.		
Parent or Guardian Signature		 Date	
Parent or Guardian Printed Name			

79 Wawecus Street, Suite 105 Norwich, CT 06360

Phone: 860-886-0161Fax: 860-889-5999

179 Flanders Road, Suite 2 Niantic, CT 06357

Phone: 860-691-0253Fax: 860-691-0285

489 Gold Star Hwy, Suite 100 Groton, CT 06340

> Phone: 860-445-2461 Fax: 860-445-8512