SAMANTHA A. TOERGE, M.D.

THE BARLOW BUILDING
5454 WISCONSIN AVE. SUITE 1400
CHEVY CHASE, MD 20815

TELEPHONE: (301) 951-7905
FAX: (301) 951-7011

Patient's Name: _____

Parent or Guardian (print): _____

Date: _____

_____ I may not come to all office visits with my child, and authorize Dr. Samantha Toerge to treat him/her in my absence. I understand that this means that Dr. Toerge will make medical decisions regarding my child's care, in consultation with my child, and that Dr. Toerge will not hesitate to call me to discuss treatment decisions when she feels that parental involvement would be advisable. I also understand that if I wish to be directly involved in the details of my child's care, I should be present at all scheduled appointments in order to allow productive discussion of possible care plans. Any time I choose not to attend an appointment, I will ensure that I have provided my child with or otherwise arranged for payment of whatever fees are due at the time of the visit.

_____ I do not wish to have my child seen when I am not present, and will be available to attend all scheduled appointments.

_____ I will not be able to attend all of my child's appointments, but agree to allow them to be accompanied by another person (name: _____). I understand that the policy outlined above for visits when a parent is not present will apply.

Signature: _____ Date: _____