

CONSENT FOR MEDICAL TREATMENT OF A MINOR

Patient Name (Last, First, MI): _____

Street Address _____ City/State/Zip _____

Telephone _____ Birthdate _____

I, the undersigned as the parent or legal guardian of the patient listed above, consent and authorize any and all medical treatment deemed necessary by Family Orthopaedics & Rehabilitation Center, LLC, or any other licensed Indiana physician of Family Orthopaedics & Rehabilitation center, LLC. As long as the medical treatment considered necessary in the situation is in accordance with generally acceptable standards of medical practice for the particular type of involved medical treatment, I impose no specific limitations regarding treatment. By signing this consent, I also understand that I will be considered the responsible billing party and will be I able for any balances left outstanding on this account after appropriate insurance filing.

This consent and authorization is effective for one (1) year. I understand it is my responsibility to notify Family Orthopaedics & Rehabilitation Center, LLC of any changes to this consent and authorization.

The persons listed below are authorized to accompany my child to his/her appointments at Family Orthopaedics & Rehabilitation Center, LLC, at any time deemed necessary.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Initials: _____ I consent and authorize my child of driving age to bring himself/herself, or a sibling, to a pre-arranged appointment without my presence.

Parent or Legal Guardian Signature **Date**

FORCE Witness **Date**