AUTHORIZATION TO TREAT A MINOR FORM

I, ____ (print name), am the parent/legal guardian of the following minor (person under the age of 18):

Patient Name: ______________________________________

Date of Birth: _______________________________________

I give consent for Beacon Orthopaedics & Sports Medicine to provide health care treatment to this minor without my presence as follows (check one):

_____ the following adult will accompany the minor in my place:

Name: ____

Relationship to Minor: ____________________________

OR

_____ the minor is 16 or older and may be seen without the presence of a parent/legal guardian or other responsible adult (this is ONLY if minor is having MRI without contrast or a follow up physical therapy visit).

This consent is (check one):
_____ effective only on _______/_______/_______ (month/day/year).

_____ effective from _______/_______/_______ to _______/_______/_______.

_____ effective until revoked by me in writing.

I understand that Beacon Orthopaedics & Sports Medicine will bill the insurance on file for charges related to my minor child's care, whether I accompany the minor or not, and I am responsible for these charges.

If this form is not completed in its entirety, it will be deemed invalid and the appointment must be rescheduled. Neither the adult accompanying the minor nor any Beacon Orthopaedics & Sports Medicine employee is permitted to make changes or additions to an Authorization to Treat a Minor form. Verbal permission (calling the staff) is never permitted.

By signing this, I acknowledge that I have read and understand this consent – and such consent may include, but is not limited to, medical treatment, testing, x-rays, injections, and the performing of whatever procedures may be deemed necessary by the treating provider. Any questions I had prior to signing this form could be answered by calling 513-354-3700.

Name of Person Completing Form: _______________________________________

*Date:*____

Signature: ____

Phone Number to Reach Parent/Guardian __________________________________