PARENTAL PREAUTHORIZATION FOR MEDICAL CARE TO CHILDREN

For families who are ongoing patients of Beacon Orthopaedics and Sports Medicine, it may be more convenient to have prior authorization for medical care delivered to minors without a parent having to be present during treatment. Please review the following authorization for treatment and complete the information if you want to Authorize such treatment in advance.

AUTHORIZATION

Physician to be seen/Service requested: _____

I (we) request and authorize the Beacon Orthopaedics and Sports Medicine and its personnel to deliver medical care to my (our) child listed below:

Child's Name: _____ DOB: _____

This authorization:

____ is effective only on _____.
month/day/year

____ is effective from _____ to _____.
month/day/year month/day/year

____ is effective until revoked by me in writing.

Signature: _____

Date: _____

Print name and relationship: _____

NOTE: If any special parental or custodial relationship (such as custody with one parent only, legal custody/ guardians with no parent, etc.) is in place, please explain in the space below with your signature, printed name, and a phone number at which you can be contacted.

_____

_____

_____

Signature: _____

Printed name: _____ Phone: _____

Fax numbers: 513-354-3765 or 513-354-3749
513-354- 7613
812-932-1040
_____

Summit Woods
Beacon West
Batesville
Beacon Location _____