Orthopedics for Kids

Consent for Treatment

Date: _____ **Patient Name** _____

Patient SSN _____ **Patient DOB** _____

I am the parent or legal guardian of the patient listed above. I understand that any decisions made with regards to the health of my child are my responsibility. However, there may be circumstances which I am unable to attend a scheduled appointment with my child. In this case, this signed and dated form shall serve to grant the rights to medical decision-making to the person(s) listed below. I recognize that subsequent office visits or further diagnostic testing may be ordered by the physician that do require my input or attendance may be required to continue in evaluating and treating my child.

Parent/Guardian Signature _____ **Date** _____

Guardian Designee Signature _____ **Date** _____

Please confirm that all required information (insurance cards, billing information, medical history updates, etc.) have been completed by the **Parent/Legal Guardian** at least 24 hours prior to your scheduled appointment to prevent delays in the child's care. Any missing or incomplete information will result in the appointment being rescheduled.