Central Indiana Orthopedics
INVESTED IN KEEPING YOU ACTIVE

Consent for Medical Treatment of a Minor

Patient Name: _____

Date of Birth: _____ Account #: _____

Problem/Injury: _____

I, the undersigned as legal guardian of the above mentioned patient, give my written permission for any and all medical treatment deemed necessary by the assigned physician at Central Indiana Orthopedics.

By signing this consent, I also understand that I will be considered the responsible billing party and will be liable for any balances left outstanding on this account after appropriate insurance filing.

_____

Signature of Parent/Legal Guardian Date

_____

Relationship to Patient

_____

Authorized Adult Witness Relation to Patient Date

_____

Name of person(s) authorized to accompany patient to their appointments

_____

Relationship to Patient