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World Class Treatment...Hometown Care

Treatment of Minors Consent Form

Patient Name: _____

DOB: _____ **Age:** _____ **Gender:** _____

I consent to care and treatment for my child related to his/ her medical appointment or physical therapy at Stevens Point Orthopedics:

On (date) _____ or dates ranging from: _____ to _____

for the following (reason for appointment) _____
with any of the Stevens Point Orthopedics authorized healthcare providers.

- My child can attend this medical/physical therapy appointment alone.
- My child will attend this appointment accompanied by:

Name: _____ Relationship: _____

If there is a need to reach me during my child’s appointment to discuss care or treatment, I may be reached at the following phone numbers:

- Home (_____) _____ - _____
- Work (_____) _____ - _____
- Cell (_____) _____ - _____
- Other (_____) _____ - _____

I further agree to reimburse Stevens Point Orthopedics for the cost of rendering these services to the extent that my insurance does not pay for these services.

Parent or legal guardian signature

Relationship to child

Printed parent/guardian name

Date Signed

Address (Street Name, City, State, Zip)