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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

____ Address (Street Name, City, State, Zip)

Send completed form to: Stevens Point Orthopedics Release of Information, 500 Vincent Street, Stevens Point, WI 54481
Fax: 715-344-4494