ORTHOPAEDIC & SPINE
CENTER OF THE ROCKIES

Consent to Treat a Minor Child

Patient/ Child Name _____ Date _____

Parent/Legal Guardian _____ Account # _____

Address _____

Work Phone _____ Home Phone _____

I,_____ authorize the Orthopaedic Center of the Rockies to perform all necessary services (evaluation, x-rays, physical therapy, and/or surgery), on my minor child, _____ related to _____ , in the absence of my presence.
(condition/symptoms)

Further, I understand that payment is due at the time services are rendered. I authorize the Orthopaedic Center of the Rockies to furnish my insurance company all information which the insurance company may request concerning my child's present illness or injury. I hereby assign to the Orthopaedic Center of the Rockies all money to which I am entitled for medical and/or surgical expense relative to the services rendered, but not to exceed my indebtedness to the Orthopaedic Center of the Rockies. It is understood that any money received from my insurance company over and above my indebtedness will be refunded when my bill is paid in full. I understand that I am financially responsible to the Orthopaedic Center of the Rockies for all charges, including those not covered by my insurance.

Signature: _____ Date: _____
Parent/Guardian

Signature: _____ Date: _____
Witness

Printed Name: _____
Witness