Orthopedic Specialists & Sports Medicine

An OrthoAlliance Partner Practice

Authorization to Treat a Minor Form

I, ______________________________________(print name), am the parent/legal guardian of the following minor (person under the age of 18):

Patient Name: ____ **Date of Birth**: ______________________________

I acknowledge that, except in certain circumstances, a minor cannot be seen by an OrthoAlliance provider without a parent/legal guardian present or another responsible adult present. In order for a minor to be seen while accompanied by an adult other than the parent/legal guardian, the parent/legal guardian must complete this Form.

☐ I give consent for OrthoAlliance to provide healthcare treatment to the above-named minor without my presence. The following adult will accompany the minor in my place:

Name: ____ Relationship to the Minor: _________________________

This consent is (check one):

_______effective only on _______/_______/_______(month/day/year).

_______effective from _______/_______/_______to _______/_______/_______.

_______effective until revoked by me in writing.

For MRI or Follow-Up Physical Therapy Appointments ONLY

☐ The above-named minor is 16 or older and may be seen without the presence of a parent/legal guardian or other responsible adult. This is ONLY if the minor is having an MRI without contrast or a follow-up physical therapy appointment.

This consent is (check one):

_______effective only on _______/_______/_______(month/day/year).

_______effective from _______/_______/_______to _______/_______/_______.

_______effective until revoked by me in writing.

I understand that OrthoAlliance and its affiliates will bill the insurance on file for charges related to my minor child's care, whether I accompany the minor or not, and I am responsible for these charges.

If this form is not completed in its entirety, it will be deemed invalid and the appointment must be rescheduled. Neither the adult accompanying the minor nor any OrthoAlliance employee is permitted to make changes or additions to an Authorization to Treat a Minor form. Verbal permission (calling the staff) is never permitted.

By signing below, I acknowledge that I have read and understand this consent – and such consent includes, but is not limited to, medical treatment, testing, xrays, injections, and the performing of whatever procedures may be deemed necessary by the treating provider. Any questions I had prior to signing this form could be answered by calling my minor child's healthcare provider at OrthoAlliance.

Name of Parent/Guardian Completing Form: ____

Phone Number to Reach Parent/Guardian: ____

Signature: ____*Date:* _______________________________

Scan in as Authorization
Updated Nov 2023