Advanced Foot & Ankle Care - Authorization for a Minor

Authorization and Consent for Medical and/or Surgical Treatment of a Minor

I, _____, parent/legal guardian of the minor listed below do hereby give my authorization and consent for him/her to receive medical and/or surgical care to include, but not limited to, evaluations, procedures, x-rays, supplies, durable medical equipment, and/or other treatment recommended by any of the Doctors of Advanced Foot & Ankle Care Centers of Ohio, Inc.

I understand that I must be present at the initial appointment to discuss at length the treatment plan for the minor listed below. I understand that another adult may be authorized to bring the minor to follow up appointments. I also agree that the private health information of the said minor will be discussed with any and all of the names listed on this authorization, including the legal guardians.

In addition treatment or procedures may be rescheduled at the discretion of the physician, should a parent's involvement facilitate a more positive outcome.

I have read and signed the office policy and procedures so that I am fully aware of my financial responsibilities at the time of service and other office policies. In addition this authorization does not expire, unless the said minor is of legal age, emancipation or revoked by the legal guardian in writing.

I am, by this document, representing that I have the authority to consent for all medical/surgical care and/or treatment of the minor listed below.

Print Patient Name: _____ DOB:_____

Print Guardian's Name:_____ DOB:_____

Guardian's Phone Number(s):_____

Guardian's Signature:_____ Date: _____

Name, relationship, DOB, and Phone number of person(s) authorized to bring Minor:

_____

Name Relationship DOB Phone Number

_____

Name Relationship DOB Phone Number

_____

Name Relationship DOB Phone Number