AUTHORIZATION TO TREAT A MINOR

Date:________________________________

I hereby authorize evaluation and treatment by Colonial Orthopaedics physician, physician assistants, nurse practitioners, physical and occupational therapists for my son/daughter,____,

for _________________________________Injury (or chronic condition) under the following circumstances:

- o In the absence of a parent/legal guardian.
- o Accompanied by:____

I furthermore authorize my insurance benefits to be paid directly to above physician, realizing I am responsible for payment of non-covered services. I also authorize the release of pertinent medical information to insurance carriers.

Signature of Parent or Legal Guardian_____________________________________

Patient Name:____________________________________

Patients Account #___________________________