Consent to Treat & Evaluate a Minor Patient

The consent of a minor's parent or legal guardian must be obtained prior to providing care and treatment. When a minor is unaccompanied by their parent or legal guardian, this completed and signed consent form will serve as authorization for routine, follow up care and treatment.

_____ _____ (____)_____-_____
Name of Minor Patient | Date of Birth | Phone Number of Parent

_____ _____ ____ _____
Address | City | State | Zip Code

Please read and initial each line below:

_____ I authorize the providers of Orthopaedic Associates of Wausau and/or PRO Physical Therapy and Hand Center to provide routine follow up treatment to the above-named minor patient.

_____ Providers may require a parent/legal guardian to accompany their minor to any appointment, regardless of this consent form.

_____ I consent to the medical treatment of this minor for routine care, if unaccompanied by parent or guardian. This does not include authorization for procedures that require written consent by parent or legal guardian. This consent is valid for a period of three months from the date of signature.

_____ I understand and agree that I am financially responsible for all health care provider services rendered.

_____ I understand it is my responsibility to inform Orthopaedic Associates of Wausau and/or PRO Physical Therapy and Hand Center in writing of any changes to this authorization. If I choose to withdraw this authorization or need to make changes, I must contact the front staff of Orthopaedic Associates of Wausau at (715)907-0900.

_____ _____
Signature of Parent or Legal Guardian | Signature and Title of Witness (OAW Staff)

_____ _____
Printed Name of Parent or Legal Guardian | Printed Name of Witness

_____ _____
Date | Date