The Centers for Advanced Orthopaedics

Parental Preauthorization to Treat a Minor

Physician/Service Requested: _____

I request and authorize The Centers for Advanced Orthopaedics and its personnel to deliver medical care to my child listed below.

Minor Patient's Name: _____

DOB: _____

Current illness/ Injury: _____ **Date of Onset** _____

Limitations:

Identify and specify any limitations on the kinds of medical care and services for which this authorization is given. If none, state "none."

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Identify and specify any limitations on the time frame for which this authorization is given. If none, state "none." If “none” is chosen this authorization will be effective for 12 months or until the end of care or treatment for the identified illness/injury.

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I understand that this Preauthorization may be revoked at any time in writing to the Centers for Advanced Orthopaedics.

It is our policy that all minors being treated by our providers who are:

- Under the age of 18 years old must have at least one legal guardian present at the time of their **first visit** with our practice. This includes any previously seen patients with a “**new**” problem.

- Under the age of 18 years old must have at least one legal guardian accompany them to all **follow-up visits** unless they sign the consent below allowing an adult, greater than 18 years of age family/friend representative to accompany them or allowing for an unaccompanied appointment(s).

Understand that if we do not have this consent, we will NOT be able to provide care for a minor that does not have at least one legal guardian present. Please check one of the following:

□The minor under my guardianship is under 18 years of age and I give my consent for him/her to attend an **unaccompanied appointment,** for the continuation of treatment in conjunction with the current illness/injury.

□The minor under my guardianship is under 18 years of age and I give my consent for him/her to attend an **appointment accompanied by an adult representative greater than 18 years of age** of my choice, for the continuation of treatment in conjunction with the current illness/injury. In addition, I give consent for medical care based on the criteria below.

I confirm that the individual(s) listed below are the adult representative in my absence:

_ _

____

Name Relationship

______________________________ ______________________________

Name Relationship

□I do not wish for the minor to be seen without a parent or guardian present at each office visit.

The undersigned hereby authorizes The Centers for Advanced Orthopaedics to provide ongoing medical treatment by its licensed providers (including support staff) employed by our practice for my minor child, when such treatment is deemed necessary by such physician in conjunction with current illness/injury being treated by The Centers for Advanced Orthopaedics. I understand that I am still financially responsible for any charges/treatment authorized by appointed representative for my child.

Print Name Contact Number

Signature of parent/legal guardian Date