WELLINGTON®

Orthopaedic & Sports Medicine

Minor Patient Consent

Wellington Orthopaedics has my consent to give medical treatment to

_____ for his/her _____.

Name of Minor Body Part

I realize that if I am not present at the time of the appointment that the above named minor could possibly need x-rays and/or a cast or brace if deemed medically necessary by the treating provider.

I also realize that the above named minor could have to make decisions regarding their care in my absence.

I understand that above minor will be expected to pay any insurance co-pay at the time of service.

If I am not at the appointment and have questions the physician will be unable to take telephone calls from a parent or guardian during a busy clinic.

_____ _____

Parent/Guardian Signature Relationship to Minor

_____ _____

Printed name of parent/guardian Date