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OAWF
ORTHOPAEDIC ASSOCIATES OF WEST FLORIDA

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AUTHORIZATION FOR TREATMENT OF MINOR(S)

Patient Name _____ **Date of Birth** _____

Account Number _____ **Social Security No**. _____

Parent/Legal Guardian Name_____

I hereby request and give my permission for the physicians of Orthopaedic Associates of West Florida to provide such medical examination and treatment as they deem best for the child's physical and/or mental welfare.

As parent ( ) or legal guardian ( ), I give my full consent to physicians as named above, for office medical examination and treatment for my child. I will notify the physicians' office (OAWF) of any change in the above information or permission.

The undersigned agrees to accept full responsibility for all charges due upon receipt of statement. I direct my insurer and third parties to pay directly to the physicians' office (OAWF) any insurance benefits due for services on behalf of the patient. I hereby assign to the physicians' office (OAWF) all my rights to receive payments from my insurer and third parties for services rendered by physicians' office. I understand that I am responsible for any costs incurred in the collection of the patient's account in case of default, including reasonable attorney fees and/or court costs. I understand that my credit history, as part of public records, may be requested by OAWF.

I agree that unless I give specific instructions otherwise, medical information regarding my child's diagnosis and treatment may be released to the natural mother, natural father, stepmother/father, referring physician, other physicians involved in the care of my child, and my insurance company (ies).

Signature_____ Date _____

In the event of my absence, I _____parent/legal guardian of the above patient,

give permission to _____ to seek medical treatment for my child.

Signature _____Date _____