DMOS ORTHOPAEDIC CENTERS

Minor Patients in Clinic Authorization Form

PERMISSION TO ACCOMPANY A MINOR WITHOUT THE PRESENCE OF A PARENT/GUARDIAN

By law, any child under the age of 18 years old cannot be seen by a doctor without written consent from a parent or without an authorized decision maker present. If the minor is under 16, he/she must be accompanied by an adult (unless the minor 16 or over is within a Global Service Period). If the minor arrives with someone other than a parent or legal guardian, DMOS must have written permission from the parent or legal guardian that this person has been appointed by the parent to act on the parent or authorized adult's behalf.

Minor's name: _____ **DOB**: _____

For those occasions when you may not be with your child, **please list those individual(s) age 18 or older who may give us consent for care:**

Name: _____ Phone: _____ Relationship to Patient: _____

Name: _____ Phone: _____ Relationship to Patient: _____

Child's Health Information: Current prescribed or over-the-counter medications and dosages:

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Allergies, illnesses or other comments: _____

Health Insurance Information: ❒ No change since last visit *(skip to next section)*

Insurance Company: _____ Policy Holder: _____

ID Number: _____ Group Number: _____

Effective Date: _____ Copay: _____

AUTHORIZATION: I (parent/legal guardian name) _____ request and authorize DMOS and its personnel to deliver orthopaedic medical care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. I am also aware that I am responsible for payment of the patient portion at the time of service. I have the legal right to preauthorize DMOS and its personnel to deliver medical treatment and services to my child. Medical care and interventions may include, but are not limited to: medical evaluation, physical exam, injections, x-rays, lab work (examples: throat or nasal swabs, blood draws, wart treatment with liquid nitrogen, minor burns, minor suturing of lacerations) I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand.

LIMITATIONS: Identify any specific limitations on the kinds of medical services for which this authorization is given.

(If none, state "none"): _____

Phone # for Parents/Guardians – you must be available by phone at time of visit: _____

This consent shall be in effect for: ☐ Date: _____ (only) ☐ indefinitely, until revoked by written notice.

Parent/Legal Guardian (please print): _____ Relationship to Patient: _____

Parent/Legal Guardian Signature: _____ Date: _____