



**Consent to Medical Treatment and Responsibility for Medical Charges**  
(For Minors under the age of 18 years old)

**Please Print**

**Chart Number**

\_\_\_\_\_  
Patient's Name (Last, First, Middle)

I, \_\_\_\_\_, (parent/guardian) of \_\_\_\_\_,  
whose birth date is \_\_\_\_\_ (MM/DD/YYYY) hereby authorize University  
Specialty Clinics – Orthopaedics to treat said minor on or after the following date  
\_\_\_\_\_ (MM/DD/YYYY) for any and all treatment including, but not limited to,  
physical examinations, x-rays, laboratory procedures, and other procedures related to routine diagnosis  
and treatment as determined appropriate by the practice's physicians, healthcare providers, associates,  
consultant and residents.

I understand and agree that it is my responsibility to provide the patient with the appropriate  
insurance information at the time of visit and authorize University Specialty Clinics – Orthopaedics to  
bill my insurance company on my behalf. I also understand that if no insurance information is presented  
at the time of visit, I accept financial responsibility for all charges incurred in the course of treatment.

I understand and agree that I am responsible for obtaining any pre-authorization required by my  
insurance company. If authorization is not obtained prior to scheduled visit, I understand that the visit  
may have to be rescheduled until pre-authorization has been obtained. If treatment is provided without  
my obtaining a pre-authorization required by my insurance company, I accept financial responsibility for  
all charges incurred in the course of treatment.

This consent expires upon the patient's 18<sup>th</sup> birthday unless revoked in writing.

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Printed Parent/Guardian's Signature

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date (MM/DD/YYYY)

\_\_\_\_\_  
Insurance Name

\_\_\_\_\_  
Insurance Policy Number