4700 Hale Parkway Suite 550
Denver, CO 80220

Office 303-321-6600
Fax 303- 321-8814

Permission for Treatment of a Minor
(Must be completed in conjunction with the patient Information form)

Minor's Legal Name: _____ Date of Birth: _____

Address: _____ City / State: _____ Zip code: _____
(If different than responsible party)

Parent Phone #: _____ Date of Treatment: _____

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Permission to Treat a Minor

I authorize Orthopedic Associates to treat my child without my presence in the office. I grant permission for x-rays to be taken or office procedures to be performed if deemed necessary by the treating Physician and/or Physician Assistant. This is valid for one year of signing or the minor turns 18 years of age.

I understand that I am financially responsible for all charges incurred.

_____ _____
Parent or Legal Guardian Name (printed) Parent or Legal Guardian Name signature)

Date: _____
(Today's)

Billing Information
(Please provide a photo copy of front and back of insurance card)

Name of Guarantor: _____ Phone #: _____

Address: _____ City / State: _____ Zip code: _____

Insurance Policy Holder: _____ Phone #: _____
(If different from Guarantor)

Insurance Company: _____

Policy #:_____