Children's Orthopedic Specialists

THE ONLY PRACTICE DEDICATED TO PEDIATRIC ORTHOPEDICS
IN SOUTHERN ARIZONA

OFFICE POLICIES

CONSENT FOR TREATMENT OF A MINOR

I, the Parent or Legal Guardian of (Patient Name)____________________ (Date of Birth)____________, Who is a minor, authorize Children's Orthopedic Specialists (COS) and all persons acting as agents thereof and all physicians to who said minor is referred for medical treatment and all forms of diagnostic; preventative and medical treatment to said minor. This consent shall remain in effect until a written revocation hereof is delivered to COS.

AUTHORIZATION AND RELEASE

I authorize COS, to release any information including records of the diagnosis or treatment rendered to my child during the period of such care to third party payors and / or other healthcare practitioners. I authorize and request my insurance company to pay directly to COS insurance benefits otherwise payable to me.

PAYMENT POLICY

I understand that all co-payments and deductibles are due at time of service.

I understand the my insurance may not cover some services or materials provided and I agree to be responsible for the difference.

I will promptly respond to my insurance company's requests for additional information.

I realize that after 45 days, outstanding balances will be assigned to collection services with an additional $25 service fee.

I am the parent of said minor child, or the court appointed guardian for the patient and am authorized to act on the patients behalf to sign this Release of Information, and agree to all terms above.

______________________________	______________________________	__________
Signature of Parent /Guardian of Patient	Print Name of Parent /Guardian of Patient	Date