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Proxy Consent to Treat Minors Form

This form may be used to allow an individual other than the parent or legal guardian to serve as proxy decision maker for routine orthopedic care and services at Children First Orthopedics.

For some families it may be convenient to have prior authorization in place that allows routine orthopedic care to be delivered to minors under the care of a proxy decision maker if a parent or legal guardian cannot be present to provide consent. If you would like to appoint a proxy decision maker, please review and complete the following form authorizing orthopedic treatment or services for the care of a minor child.

Authorization

I hereby appoint _____
Name Relationship
as a proxy decision maker to consent to and authorize orthopedic care for my child listed below:

This proxy extends to care deemed necessary by the physician to treat the conditions present. This consent includes but is not limited to, the taking of medical history, performance of medical examination, the taking of diagnostic x-rays, and the application of a brace or cast if necessary. I understand that treatment recommended and rendered is based on what the physician believes to be in the best interest of the patient. This treatment is not based on insurance coverage. I understand that failure of an insurer to pay for a procedure does not relieve me of the financial obligation for this treatment.

Child's Name: _____ DOB: _____

Limitations

Identify any limitations on the kinds of medical services for which this authorization is given. If none, state none. _____

Contact Information

Father's Name: _____ Mother's Name: _____
Daytime Phone: _____ Daytime Phone: _____
Cell Phone: _____ Cell Phone: _____

I hereby indemnify and hold harmless Children First Orthopedics from any and all liability for acting in reliance on this authorization. The individual appointed as proxy is permitted to make decisions or consent to care in my absence. I agree to accept financial responsibility for all the care delivered pursuant to this authorization.

Signature of Parent or Legal Guardian

Relationship to Patient

Date

This form is valid for one year from the date of signature.