CONSENT FOR TREATMENT OF UNACCOMPANIED MINOR

Name of Minor: _____ ("Minor")

Date of Birth of Minor: _____

I acknowledge that I am the parent or guardian entitled to the care, custody, and control of Minor.

I represent that I am unable to accompany Minor to his/her appointment with OrthoCarolina, PA. on the _____ day of _____, 20___ for examination or treatment.

I hereby request, authorize and direct OrthoCarolina, PA. to examine and treat Minor in my absence.

I understand that, in certain circumstances, the healthcare providers of OrthoCarolina, PA may require that a parent or other authorized adult be present with Minor to assist in the diagnosis or treatment process. I agree to cooperate by being present at all times possible and when specifically requested by OrthoCarolina, PA.

Name: _____

Signature: _____

Relationship: _____

Date: _____

YOU. IMPROVED.

OrthoCarolina