Consent to Treat Patient – Without Parent /Legal Guardian Present

By law, any child under the age of eighteen (18) years old cannot be seen by a physician without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

Florida Bone and Joint Specialists, LLC, Steven C Kronlage, MD, P.A., Ortho JNN LLC and The Hand Center Imaging Solutions, L.L.C., must receive permission, from a child's parent or legal guardian, prior to providing treatment(s) for preventative care, injury or illness that is non-life threatening. This form provides the legal permission to (depending on the minor's age) to either treat without any adult present (Section A), or with a Designated adult present (Section B).

Patient's Legal Name:	
Patient's Date of Birth:	
Allergies:	
Current Medications:	
Chronic Conditions:	

Section A: (ONLY for child at least 16, but not 18 years old)

Authorization to treat your minor child in case you or your designated representative are unable to accompany your child to one of his/her visits: I, (print parent/legal guardian name) _____ grant Florida Bone and Joint Specialists, LLC, Steven C Kronlage, MD, P.A., Ortho JNN LLC and The Hand Center Imaging Solutions, L.L.C., permission to assess and treat the aforementioned minor without an adult present. I also agree to be financially responsible for payment of all charges in connection with the care and treatment rendered.

Section B: (for child under 18 years old)

Delegation of authority for medical treatment of a minor child to the designated representative indicated below:
I, (print parent/legal guardian name) _____grant Florida Bone and Joint Specialists, LLC, Steven C Kronlage, MD, P.A., Ortho JNN LLC and The Hand Center Imaging Solutions, L.L.C., to assess and treat the aforementioned minor in the presence of either of the following adults (you may choose more than one), who is authorized to approve treatment:

Name: _____ Relation to minor _____
Name: _____ Relation to minor _____

LIMITATIONS:
Identify any **specific limitations** on the kinds of medical services for which this authorization is given.
(If none, state "none")
_____

AUTHORIZATION:
I (parent/legal guardian name)_____ request and authorize Florida Bone and Joint Specialists, LLC, Steven C Kronlage, MD, P.A., Ortho JNN LLC and The Hand Center Imaging Solutions, L.L.C., and its personnel to deliver routine medical care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child, I am also aware that the adult presenting the child is responsible for payment of the patient portion at the time of service.

I have the legal right to preauthorize Florida Bone and Joint Specialists, LLC, Steven C Kronlage, MD, P.A., Ortho JNN LLC and The Hand Center Imaging Solutions, L.L.C., and its personnel to deliver routine medical treatment and services to my child. Routine Medical care and interventions may include, but are not limited to: medical evaluation, physical exam, routine immunizations, injections, x-rays, lab work (examples: throat or nasal swabs, blood draws, urine catheterizations, minor burns, minor suturing of lacerations)

Insurance card(s) and co-pay amounts (if applicable) must be presented at each visit

I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand.

_____

Parent or Legal Guardian (please print) Relationship

_____

Parent or Legal Guardian Signature Date

Parent or Legal Guardian
Emergency Contact Phone #1 _____
Emergency Contact Phone #2 _____