AUTHORIZATION TO TREAT AN UNACCOMPANIED MINOR

Date_____

Patient Name_____Chart #_____

SSN_____Date of Birth_____

As the parent or legal guardian of the above named minor, I hereby grant permission to the Members of the medical staff of Bayside Orthopaedic, Sports Medicine & Rehabilitation Ctr to render medical care to him/her, waiving the necessity for me to be present.

Check each item that applies:

- ❑ My child may come in for regularly scheduled appointments for continuing care by the physician or physical therapy department.
- ❑ This child has my permission to seek care, unattended by an adult, at this practice.
- ❑ My child is a student athlete at one of Baldwin County's public schools and I give my permission for my child to be accompanied by a member of the sports coaching team or Encore Rehabilitation Sports Medicine trainers for initial evaluation or continuing treatment of a sports related injury or condition.

I further understand that all financial obligations are mine. I agree to pay for all co-pays, deductibles, or personal balances at each regularly scheduled appointment in the same manner as if he/she were accompanied by the parent or guardian.

I will keep Bayside Orthopaedic Center informed of any changes in insurance coverage, cell phone numbers, work phone numbers, etc. so that the Physician will be able to reach me if it is necessary to discuss my child's care or condition.

_____ _____

Signature of Parent or Guardian Witness

Printed name of Parent or Guardian	Printed Name of Witness