



Orthopedic Surgery

Physical Medicine & Rehabilitation

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**CONSENT TO TREATMENT OF A MINOR**

Minor's Name: \_\_\_\_\_

I, the undersigned, attest that I am the custodial parent or legal guardian of the above-referenced

Minor ("the minor"), and hereby authorize North Texas Orthopedics to administer treatment as it so deems necessary to the minor. In no event shall my signature to any other such document have any effect on this consent form.

Name of Custodial Parent / Legal Guardian (please spell clearly):

\_\_\_\_\_

Relationship to the minor:

- Custodial Parent
- Guardian by Law Date Guardianship Commenced \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- Other (please specify) \_\_\_\_\_

Social Security # of Parent / Guardian: \_\_\_\_ \_\_\_\_ \_\_\_\_ / \_\_\_\_ \_\_\_\_ / \_\_\_\_ \_\_\_\_ \_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address of Parent / Guardian: \_\_\_\_\_

Home Phone # (\_\_\_\_) \_\_\_\_\_ Work Phone # (\_\_\_\_) \_\_\_\_\_

The listed person(s) below has permission to bring \_\_\_\_\_ for follow-up or subsequent visits:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ ID \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ ID \_\_\_\_\_

My son, daughter is 16 years of age or older and has my permission to be seen on follow-up or Subsequent visit without parent / guarding attending. \_\_\_\_ Yes \_\_\_\_ No

This authorization will expire 6 months from date signed.

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Witness' (if any) Name \_\_\_\_\_

Witness' Signature \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_