



CHIPPEWA VALLEY ORTHOPEDICS TREATMENT OF MINOR CONSENT FORM

Patient Name:		
DOB:	Age:	Gender:

CONSENT

To comply with Wisconsin law, Chippewa Valley Orthopedics requires that a parent (not step-parent/foster parent) or legal guardian (guardian appointed by a court) accompany any minor children (17 years old or younger) to their medical (to include possible x-ray/ MRI/CT scan) appointments. In the event that a parent or legal guardian is unable to accompany his or her minor child to a medical treatment appointment, the parent or legal guardian must sign this consent form for treatment of minors.

Name of parent or legal guardian: _____

Name of child _____

I consent to care and treatment for my child related to his/her medical treatment appointment at Chippewa Valley Orthopedics:

Date of care/treatment: ____/____/____

If my child is under the age of 18 y.o., he/she is not able to attend this medical treatment appointment alone. Please list the name of the individual that will accompany my daughter/son.

Name _____ Relationship _____
will accompany my child at this appointment.

If there is a need to reach me during my child's appointment to discuss further care or treatment, I may be reached at the following phone numbers:

Home: (____) _____ - _____

Work: (____) _____ - _____

Cell: (____) _____ - _____

I further agree to reimburse Chippewa Valley Orthopedics/health care provider for the cost of rendering these services to the extent that my insurance does not pay for these services:

Child's parent or legal guardian signature

Relationship

Print child's parent or legal guardian name

Date (month/day/year)

Child's parent or legal guardian address