THE HAND & WRIST CENTER
Specialists in diagnoses, rehabilitation and surgery

# CONSENT TO CONSULT AND TREAT "MINOR" PATIENT

(IN ABSENCE OF PARENT OR LEGAL GUARDIAN)

**TODAY'S DATE:** _____

**PATIENT NAME (MINOR):** _____

**PATIENT'S DATE OF BIRTH:** _____

**PRIMARY** PARENT / LEGAL GUARDIAN NAME: _____

**ADDRESS:** _____

**TELEPHONE:** _____ ***RELATIONSHIP:** _____

***ATTACH COPY OF PHOTO ID (if one is not already on-file).**

**SECONDARY** PARENT / LEGAL GUARDIAN NAME: _____

**ADDRESS:** _____

**TELEPHONE:** _____ ***RELATIONSHIP:** _____

***ATTACH COPY OF PHOTO ID (if one is not already on-file).**

**CONSENT ACKNOWLEDGEMENT:**

I/we understand that minors are required to be accompanied by a parent or other legal guardian on each visit. I/we understand that, without a signed consent, ***The Hand & Wrist Center*** cannot provide consultation or treatment to a minor if their parent or legal guardian are not present. I/we acknowledge that on my/our behalf, neither is available to accompany my/our minor to the Center.

I/we hereby give my/our "Consent" for ***Ross Nathan, M.D., George A. Macer, M.D., John F. Cook, M.D.*** and the Staff at ***The Hand & Wrist Center*** to provide consulation and treatment to my/our minor, in my/our absence. Furthermore, I/we hereby release ***Ross Nathan, M.D., George A. Macer, M.D., John F. Cook, M.D.*** *and* ***The Hand & Wrist Center*** from any liability that may occur, in relation to my/our minor, in my/our absence.

I/we deem this consent valid for the following duration:

☐ **Today's visit only.**

☐ **For the period / duration of care.**

**My/our signature(s) below acknowledge(s) that the above-stated information is true and enforced immediately .**

**PARENT / LEGAL GUARDIAN SIGNATURE(S):**

**PRIMARY:** _____ **DATE:** _____

**SECONDARY:** _____ **DATE:** _____