THORNAPPLE RIVER ORTHOPEDICS

Today's Date:_____

Consent for treatment of a minor:

Please list the name and date of birth of the minor child below.

Patient Name	Date of Birth

I,_____, parent/ guardian give consent to the individuals listed below to act
(Printed Name of parent/ guardian)

on my behalf for the minor listed above to authorize surgical or medical treatment that is deemed necessary or advisable by the providers of Thornapple River Orthopedics.

My signature below certifies that I accept any financial charges for surgical or medical treatment and that the information provided is true and accurate.

Name:	Relationship to Patient:	Phone:

Signature:_____Date:_____