Texas Orthopedics,
Sports & Rehabilitation Associates
www.txortho.com

AUTHORIZATION TO TREAT MINOR

Date: _____

I hereby authorize evaluation and treatment by Texas Orthopedics physicians, physician assistants/clinical nurse specialists, physical therapists and/or occupational therapists for my son/daughter, _____, for the _____ injury (or chronic condition) under the following circumstances:

☐ In the absence of a parent/legal guardian.

☐ Accompanied by: _____

I furthermore authorize my insurance benefits to be paid directly to above physician, realizing I am responsible for payment of non-covered services. I also authorize the release of pertinent medical information to insurance carriers.

_____
Signature of Parent or Legal Guardian

Patient Name _____

Patient Account # _____