BRIDGER ORTHOPEDIC

AUTHORIZATION TO CONSENT TO TREATMENT MINOR PATIENT
IN ABSENCE OF PARENT/GUARDIAN

On occasion, I will not accompany my child to his/her visit. I, the undersigned parent/guardian of

_____ a minor, do herby authorize Bridger Orthopedic and attending medical personnel to examine, treat, perform diagnostic testing as indicated and advise my child regarding his/her treatment, illness, injury, and or any other health concern without my presence.

I understand that the above list is not all-exclusive and serves only as a means of example as to the type of examinations or discussions that may occur with my child.

I understand, that at all times, I remain ultimately responsible for all care rendered to my child, including Non-Covered services. I further authorize Bridger Orthopedic to release all pertinent information to insurance carriers and other applicable third-party payors to obtain payment for any service rendered to my child.

This authorization will remain effective until my child reaches the age of eighteen. I understand that I may revoke this consent in writing at any time.

_____	_____
Print Name of Parent or Legal Guardian	Print Name of Parent or Legal Guardian
_____	_____
Relationship to Minor	Relationship to Minor
_____	_____
Signature of Parent or Legal Guardian	Signature of Parent or Legal Guardian
_____	_____
Date	Date