



Northwest Ohio Orthopedics & Sports Medicine, Inc.

Consent for Minor to Receive Treatment

I, _____, the parent/guardian of _____,
(Parent/guardian name) (Minor child's full name and date of birth)

give consent for my child to receive the following medical services at Northwest Ohio Orthopedics and Sports Medicine, Inc. ("NWO"): _____, that could include:

- Imaging services: CT, MRI, Ultrasound
- Physical/Occupational Therapy/ DME
- Chiropractic Care
- Pain Management

Choose applicable:

- A parent will be present for all visits.
- I designate the following adult to give informed consent for medical services as listed above in my absence:

(Authorized adult name and relationship to child)

- (For child age 16 until 18) I give permission to my child to attend his/her appointment alone without my presence (or the presence of another authorized adult). This includes providing the medical services listed above, obtaining a history of current illness, disclosure of protected health information, and responsibility for relaying any diagnosis, treatment plan, or prescription(s) to me. I agree to be available by phone if NWO needs to contact me during my child's appointment.

I understand that this consent form will be valid until _____ (date) or until minor turns the age of 18.

Except to the extent that the law requires my child's signed consent prior to disclosure, I understand that I will be entitled access to medical information concerning services provided to my child pursuant to this consent. I understand that nothing in this consent affects the ability of the NWO to provide medical services to my child without my consent to the extent expressly permitted under Ohio law.

I understand that I will be responsible for payment for any charges relating to services provided to my child pursuant to this consent, to the extent that such services are not covered in full by insurance or other third-party payor covering my child. NWO may release information regarding treatment to third party payers for billing purposes.

I agree that if at any time, I no longer want the adult(s) named above to consent to treatment on behalf of my child, I will immediately notify NWO in writing by sending a letter to **Northwest Ohio Orthopedics & Sports Medicine, Inc.** The revocation will be effective 5 business days after receipt to allow time for processing. The revocation will be deemed a revocation of this consent in its entirety. I understand that if I want to allow for any future authorization for treatment of my child, I will have to complete and sign a new consent form.

Signature of Parent / Legal Guardian

Date

10/2018

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