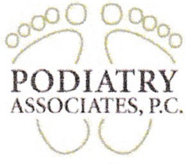
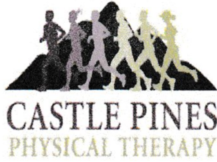




www.footdoctorscolorado.com
www.castlepinesphysicaltherapy.com
Phone: 303-805-5156
Fax: 303-805-5157

Castle Pines Foot and Ankle Clinic, P.C.
7505 Village Square Dr., Ste. 101
Castle Pines, CO 80108

Parker Foot and Ankle Clinic, P.C.
9397 Crown Crest Blvd., Ste. 311
Parker, CO 80138

Podiatry Associates at Cherry Creek, P.C.
300 S. Jackson St., Ste. 310
Denver, CO 80209

Podiatry Associates at Aurora
1444 S. Potomac St., Ste. 230
Aurora, CO 80012

PERMISSION TO TREAT A MINOR

(between the ages of 16-17)

Patient Name: ________________________________ Patient Date of Birth: ______________________

I, the parent/guardian of the above-named patient, give permission for my child to receive medical treatment at Podiatry Associates, PC and/or Castle Pines Physical Therapy in my absence. Treatment may include, but is not limited to, physical therapy, routine care, wart care, general follow-up to previous care and additional x-rays (as needed). I understand that my presence is mandatory for in-office procedures, surgical procedures and when/if the physician determines it is necessary. I agree to be available by phone and understand that I am financially responsible for any/all charges (i.e., co-pays, co-insurance) incurred during my child's treatment in my absence.

Parent/Guardian Name (please print): ________________________________

Parent/Guardian Signature: ________________________________ Date: ______________________

Parent/Guardian Phone Number: ________________________________

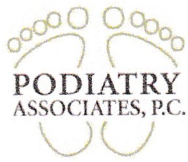
**This authorization will be effective for 6 months from the date of signing. If you wish to specify a timeline less than that, please provide the end date here:* ______________________.

Health Insurance Information ☐ **No change since last visit**

Insurance Company: ______________________ Policy Holder: ______________________

ID Number: ______________________ Group Number: ______________________

Effective Date: ______________________ Co-pay: ______________________



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PERMISSION TO ACCOMPANY A MINOR

Patient Name: ______________________________ Patient Date of Birth: ____________________

I, the parent/guardian of the above-named patient, give permission for my child to receive medical treatment at Podiatry Associates, PC and/or Castle Pines Physical Therapy under the supervision of my designee, listed below as the "Temporary Guardian." My designee will act in my stead in all regards including, but not limited to, bringing the child into the office of Podiatry Associates, PC, providing a history of present illness, disclosing protected health information, accompanying consented research study procedures, witnessing exams completed by providers and authorizing medical treatment. I understand that it is my responsibility to obtain information regarding my child's diagnosis, treatment plan and prescription medication from my designee.

I agree to be available by phone and understand that I am financially responsible for any/all charges (i.e., co-pays, co-insurance) incurred during my child's treatment.

Temporary Guardian Name (please print): ______________________________

Temporary Guardian Address: ______________________________

Temporary Guardian Phone Number: ______________________________

Temporary Guardian Relationship to Patient: ______________________________

Parent/Guardian Name (please print): ______________________________

Parent/Guardian Signature: ______________________________ Date: ____________________

Parent/Guardian Phone Number: ______________________________

**This authorization will be effective for 6 months from the date of signing. If you wish to specify a timeline less than that, please provide the end date here:* ____________________.

Health Insurance Information ☐ **No change since last visit**

Insurance Company: ____________________ Policy Holder: ____________________

ID Number: ____________________ Group Number: ____________________

Effective Date: ____________________ Co-pay: ____________________