PODIATRY ASSOCIATES, P.C.
7505 Village Square Dr., #101
Castle Pines, CO 80104
Phone: 303-805-5156
Fax: 303-805-5157

PERMISSION TO ACCOMPANY A MINOR

I, _____, give permission to _____
(Name of Parent/Guardian) (Name of adult to be accompanying child)

to accompany my child _____ and authorize treatment for my
(child's name and DOB)

child in accordance with the office policy of Podiatry Associates, PC. This includes 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, treatment including both Physical therapy/Podiatry and witnessing any exams completed by the provider. This adult has the responsibility to relay any diagnosis, treatment plan or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone and to be financially responsible for all copays and coinsurance.

This authorization is effective from: _____ to _____.
(effective date) (end date ≤6 months)

Emergency Contact Information for Parents/Guardians:

Who is to be contacted in case of emergency? _____
Phone: _____

Temporary Guardian Information

Name: _____ Phone: _____
Address: _____
Relationship:_____

Health Insurance Information ❒ No change since last visit *(skip to next section)*

Insurance Company:_____ Policy Holder: _____
ID Number: _____ Group Number: _____
Effective Date: _____ Copay: _____

Parent or Legal Guardian's Signature: _____ Date:_____

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PERMISSION TO TREAT A MINOR

I, _____, give permission for my Child whom is
(Name of Parent/Guardian)

between the ages of 16 and 17 _____
(child's name and DOB)

to be treated in my absence for Physical Therapy, routine care and follow-ups which include but are not limited to wart care, general follow up to previous care, additional x rays if needed. I understand I must be present if any in office or surgical procedure is performed or if the physician feels it necessary for me to be present in accordance with the office policy of Podiatry Associates, PC. I agree to be available by phone and to be financially responsible for all copays and coinsurance.

This authorization is effective from: _____ to _____.
(effective date) (end date ≤6 months)

Emergency Contact Information for Parents/Guardians:

Who is to be contacted in case of emergency? _____
Phone: _____

Health Insurance Information ❒ No change since last visit *(skip to next section)*

Insurance Company:_____ Policy Holder: _____
ID Number: _____ Group Number: _____
Effective Date: _____ Copay: _____

Parent or Legal Guardian's Signature: _____ Date:_____