



KAMIL ORTHOPAEDIC GROUP

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CONSENT FOR TREATMENT OF A MINOR

I, _____ being the parent or legal guardian of _____
(Name of child)

Give consent for medical treatment of this minor in the event of my absence. I grant my permission for treatment by a licensed physician, or other practitioner, including such clinical personnel as the physician deem necessary. I am aware the practice of medicine is not an exact science and that no guarantees can be made concerning the results of treatment.

The minor named in this consent may receive all treatment provided according the generally accepted standards of medical practice with the following limitations (if none write None) _____

My consent is effective for the following appointment(s) Date: _____ or all appointments _____

PARENT/LEGAL GUARDIAN

Name _____

Address _____ City _____

State _____ Zip _____

Phone: _____ Cell _____ Work _____

OTHER CONTACT PERSON

Name _____

Address _____ City _____

State _____ Zip _____

Phone _____ Cell _____ Work _____

I am aware that I am responsible for all charges not covered by insurance

MEDICAL INSURANCE

Name of Insured _____

Relation to patient _____

Company Name _____

Group number _____

ID Number _____

Primary Care Physician Name _____

Phone number _____

Signature of parent or guardian

Date