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8839 Bryan Dairy Rd., Suite 240 • Largo, FL 33777 • Phone 727-461-6026 • Fax 727-397-0562  
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Patient Name : \_\_\_\_\_ Date of Birth \_\_\_\_\_

Account # \_\_\_\_\_ Social Security # \_\_\_\_\_

Parent/Legal Guardian Name \_\_\_\_\_  
(please print)

### AUTHORIZATION FOR TREATMENT OF MINORS

I hereby request and give permission for the physicians of Orthopaedic Associates of West Florida to provide such medical examination and treatment as they deem best for my child's physical or mental welfare.

As parent ( ) or legal guardian ( ), I give my full consent to physicians William C. Cottrell, M.D., John E. Kilgore, M.D., John McClure, M.D., Andrew C. Messer, M.D., Richard Pigeon, M.D., Michael L. Rothberg, M.D., Thomas O. Schwab, M.D., Craig A. Schwartz, M.D., Jennifer Swaringen, M.D., Nishin Tambay, M.D., David P. Thompson, M.D., Scott M. Wisotsky, M.D., for medical office examination and treatment for my child. I will notify the physicians' office of any change in the above information or permission.

The undersigned agrees to accept full responsibility for all charges due upon receipt of statement. I direct my insurer and third parties to pay directly to the physician's office any insurance benefits due for services on behalf of the patient. I hereby assign to the physician's office all my rights to receive payments from my insurance and third parties for services rendered by physician's office. I understand I am responsible for any costs incurred in the collection of the patient's account in case of default, including reasonable attorney fees and/or court costs. I understand that my credit history, as part of public record, may be requested by Orthopaedic Associates of West Florida.

I agree that unless I give specific instructions otherwise, medical information regarding my child's diagnosis and treatment may be released to the natural mother, natural father, stepmother/father, referring physician, other physicians involved in the care of my child, and my insurance company(ies).

Signature \_\_\_\_\_ Date \_\_\_\_\_

In the event of my absence, I \_\_\_\_\_ parent or legal guardian of the above named patient, give permission to \_\_\_\_\_ to seek medical treatment for my child.

Signature \_\_\_\_\_ Date \_\_\_\_\_