

**CONSENT TO CONSULT AND TREAT "MINOR" PATIENT**  
(IN ABSENCE OF PARENT OR LEGAL GUARDIAN)

TODAY'S DATE: \_\_\_\_\_

PATIENT NAME (MINOR): \_\_\_\_\_

PATIENT'S DATE OF BIRTH: \_\_\_\_\_

PRIMARY PARENT / LEGAL GUARDIAN NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ \*RELATIONSHIP: \_\_\_\_\_

**\*ATTACH COPY OF PHOTO ID (if one is not already on-file).**

SECONDARY PARENT / LEGAL GUARDIAN NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ \*RELATIONSHIP: \_\_\_\_\_

**\*ATTACH COPY OF PHOTO ID (if one is not already on-file).**

**CONSENT ACKNOWLEDGEMENT:**

I/we understand that minors are required to be accompanied by a parent or other legal guardian on each visit. I/we understand that, without a signed consent, **The Hand & Wrist Center** cannot provide consultation or treatment to a minor if their parent or legal guardian are not present. I/we acknowledge that on my/our behalf, neither is available to accompany my/our minor to the Center.

I/we hereby give my/our "Consent" for **Ross Nathan, M.D., Kourosh M. Kolahi, M.D.** and the Staff at **The Hand & Wrist Center** [collectively referred to as **The Hand & Wrist Center**] to provide consultation and treatment to my/our minor, in my/our absence. Furthermore, I/we hereby release **The Hand & Wrist Center** from any liability that may occur, in relation to my/our minor, in my/our absence.

I/we deem this consent valid for the following duration:

\_\_\_\_\_ **Today's visit only.**

\_\_\_\_\_ **For the period / duration of care.**

**My/our signature(s) below acknowledge(s) that the above-stated information is true and enforced immediately .**

**PARENT / LEGAL GUARDIAN SIGNATURE(S):**

PRIMARY: \_\_\_\_\_

DATE: \_\_\_\_\_

SECONDARY: \_\_\_\_\_

DATE: \_\_\_\_\_