PARENTAL AUTHORIZATION

I, _____, certify that I am the parent/legal guardian of _____, a minor ("Child"), and that I am authorized to provide informed consent for any medical treatment provided to my child. I hereby give my express consent for Nebraska Orthopaedic Center ("Clinic") to perform the following procedures on my child:

☐ Diagnostic procedures such as aspiration, x-rays, and physical examination
☐ Medical and surgical treatment as deemed necessary by the Clinic healthcare provider(s)
☐ Ongoing treatments or therapy (e.g., cast rechecks, and Post-Op and Follow-Up appointments

I understand the nature of the treatment or procedures, and I acknowledge that no guarantees have been made to me or my child as to the results of treatment or examination performed at the Clinic.

Furthermore, I acknowledge that I am financially responsible for all medical examinations and treatments provided to my child at the Clinic. I hereby assign and authorize payment directly to the Clinic and those physician(s) providing care to my child of all third-party payor benefits otherwise payable to me. I hereby agree that the Clinic and the physician(s) may issue a receipt for any such payment and that this receipt shall be a conclusive acknowledgement by me that I have received insurance benefits from the insurance company(ies) of all obligations under the policy(ies) to the extent of such payment and for that purpose. I expressly authorize the Clinic and the physician(s) to furnish the insurance company(ies) with any information desired concerning said medical care and treatment. I understand that I am financially responsible to the Clinic and the physician(s) for charges not covered by this assignment and further agree to guarantee prompt payment in full of any balance due.

A photocopy of this document shall be considered as valid as the original.

_____ _____

Date Printed Name of Parent or Legal Guardian / Guarantor

_____

Signature of Parent or Legal Guardian / Guarantor