Linking our community to orthopaedic health
Lincoln Orthopaedic Center, P.C.

PARENTAL AUTHORIZATION
(Student Athletes)

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 Lincoln Orthopaedic Center, P.C. ("Clinic") to perform the following procedures on my child, for the duration of the school year:

Diagnostic procedures such as laboratory test, X-rays and physical examination;

Medical and surgical treatment as deemed necessary by the Clinic healthcare providers;

Ongoing treatments or therapy

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 any and 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 any and 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) in the sum specified in such receipt, and agree that such payment shall discharge the insurance company(ies) of any and 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.

I also give permission to Lincoln Orthopaedic Center, PC to release my child's medical information to the athletic coaching and training staff at the school where my child attends.

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

Dated this _____ day of ________________, _______.

Signature of Parent or Legal Guardian: Witness:

______________________________________ ______________________________________