LILJENQUIST, OLSON & REDD
ORTHOPEDIC SURGERY

The information listed below is the information for the parent/guardian who brings the child to their initial appointment. We CANNOT send bills to a parent or guardian who is not present with the child. We CANNOT do separate billing for different parent/guardians based off custody agreements.

GUARANTOR INFORMATION

Parent / Guardian Responsible for bills	
Social Security #	
Date of Birth	
Phone #	
Street Address	
City, State, Zip Code	

I understand that Liljenquist Olson & Redd Orthopedic Surgery will be sending all billing correspondents to me. I understand I am responsible for making all outstanding balances are paid.

X Guarantor Signature: ______________________________ Date: ______________

Print Minor's Name: ______________________________ Date of Birth: ______________

Minor's Name: ____ DOB: __________________

By law, any child under the age of 18 must be accompanied by a parent or legal guardian to all patient appointments.

If the minor arrives with someone other than a parent or legal guardian, we must have written consent from the parent or legal guardian that this person has been appointed by you to act on your behalf. For those occasions when you may not be able to be with your child, please list the individuals who may give us consent to see your child:

Name: ____Relationship to Patient: _______________

____ Check here if you wish to give consent for the minor to receive medical care without an accompanying adult. **This consent may ONLY apply to minors age 16 and older**. This consent shall be in effect for:
Date : __________ (only) or _____ Indefinitely, until revoked by written communication.

Limitations:

Identify any specific limitations on the kinds of medical services for which this authorization if given. (If none, state "none") ____

CONSENT TO TREAT:

I (parent / legal guardian name) ____________________________________request and authorize Liljenquist, Olson and Redd Orthopaedic Surgery and its personnel to deliver routine medical care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. As part of your medical care, we may use a HIPAA compliant AI- Powered scribe to record and document our conversations during this visit. This tool will help capture key details of your health information, allowing us to focus on your needs. I am also aware that the adult presenting the minor child or the minor child that is alone (16 or older) is responsible for payment of the patient portion at the time of service. I have read, understand and give my consent as stipulated above. My signature means that I have read this form and/ or have had it read to me and explained in the language that I can understand.

Authorization & Acknowledgment:

Parent or Legal Guardian (please print): ___________________________Relationship: ___________

Parent or Legal Guardian Signature: __________________________________ Date: ____________