DENVER SPORTS MEDICINE AND SPINE, LLC

YANI C. ZINIS, DO

Permission for Treatment of a Minor

(To be completed in conjunction with the Patient Information form)

Minor's Legal Name_____ Date of Birth_____

Address_____ City/State_____Zip_____

Parent Phone#_____ Date of Treatment_____

Permission to Treat a Minor

I authorize Denver Sports Medicine and Spine to treat my child with or without my presence in the office. I grant permission for appropriate diagnostic studies or examinations. I grant permission for treatment including procedures demed necessary by the treating Physician and/or Physician Assistant. All clinical information will be discussed with the parent/legal guardian. This is valid for one year of signing or the minor turns 18 years of age.

I understand that I am financially responsible for all charges incurred.

_____ _____

Parent or Legal Guardian Name (printed) Parent or Legal Guardian Signature

Date:_____

Billing Information

(Please provide a photo copy of front and back of insurance card)

Name of Guarantor_____ Phone#_____

Address:_____City/State/Zip_____

Insurance Policy Holder_____Phone#_____

Insurance Company:_____Policy #_____

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