Sports Medicine Associates of South Florida P.A.

□Alfred A. DeSimone, M.D., Orthopaedic Surgeon
□Fernando A. Moya, M.D., Orthopaedic Surgeon
□Alexander J. Bertot, M.D., Orthopaedic Surgeon
□David Shenassa, M.D., Hand Surgeon
□Franz Jones, D.O., Physiatrist

□ 1600 Town Center Blvd, Weston, FL 33326..(954) 389-5900
□ 17842 N.W. 2nd Street. Pembroke Pines, FL 33029 (954) 430-9901
□ 220 S.W. 84 Avenue. Plantation, FL 33324 (954) 720-1530

AUTHORIZATION FOR TREATMENT OF MINORS

Patient Name _____ **Date of Birth** _____

Parent/Legal Guardian Name _____
(please print)

I hereby request and give permission for the physician of Sports Medicine Associates of South Florida, P.A. to provide such medical examination and treatment as they deem best for my child's physical or mental welfare.

As parent ( ) or legal guardian ( ), I give my full consent to physicians Alfred A. DeSimone, M.D., Fernando A. Moya, M.D., Alexander J. Bertot, M.D., David Shenassa, M.D., Franz Jones, D.O., Eric Bronson, P.A., Paul Buchanan, P.A., Kay Ann Mullings, P.A., Trevor Kolski, P.A., Sydnee Brin, P.A., for medical office examination and treatment for my child. I will notify the physicians' office of any change in the above information or permission.

The undersigned agrees to accept full responsibility for all charges due upon receipt of statement. I direct my insurer and third parties to pay directly to the physician's office any insurance benefits due or services on behalf o the patient. I hereby assign to the physician's office all my rights to receive payments from my insurance and third parties for services rendered by physician's office. I understand I am responsible for any costs incurred in the collection of the patient's account in case of default, including reasonable attorney fees and/or court costs. I understand that my credit history, as part of public record, may be requested by Sports Medicine Associates of South Florida.

I agree that unless I give specific instruction otherwise, medical information regarding my child's diagnosis and treatment may be released to the natural month, natural father, stepmother/father, referring physician, other physicians involved int eh care of my child, and my insurance company(ies).

Signature _____ **Date** _____

In the event of my absence, I _____ parent or legal guardian of the above named patient, give permission to _____ to seek medical treatment for my child.

Signature _____ **Date** _____