

Mainsail Innovation Employee Advance Consent for Treatment of Minor

Arthrex Medical Center • 1284 Innovation Drive Suite 100, Naples, FL 34108

Your minor child may be entitled to receive medical benefits at Arthrex Medical Center. You may wish to have prior authorization in place so that medical care may be delivered directly to your minor child in the event you or another parent/legal guardian cannot be present prior to or during treatment. Please review the following authorization for treatment and complete the information if you wish to provide advance consent for treatment of your minor child.

I am the parent or legal guardian of the child listed below. I have the legal right to preauthorize Arthrex Medical Center to deliver medical treatment to my child. I request and authorize Arthrex Medical Center and its personnel to deliver medical care to my child listed below in my absence.

First Name of Child:

Last Name of Child:

Date of Birth:

I request that the medical services for which this appointment is given be limited to those medical services listed below. If none, state "none."

I request that this appointment be limited to the time period identified below. If none, state "none." This appointment shall remain in effect until revoked in writing or until the date indicated below.

Consent Form

By signing below, I agree and acknowledge all of the information, facts, terms, and conditions of this Consent Form. In Witness Whereof, the undersigned has executed this instrument as of the ____ day of _____, 20____.

Printed Name of Parent or Legal Guardian:

Printed Name of Witness:

Signature of Parent or Legal Guardian:

Signature of Witness: