THE HAND & WRIST CENTER

Kourosh M. Kolahi, M.D. / Ross Nathan, M.D. / George A. Macer, M.D.

3633 Long Beach Boulevard Suite 100, Long Beach CA 90807 T: 562.424.9000, F: 562.424.9067

CONSENT TO CONSULT AND TREAT "MINOR" PATIENT

(IN ABSENCE OF PARENT OR LEGAL GUARDIAN)

TODAY'S DATE: _____

PATIENT NAME (MINOR): _____

PATIENT'S DATE OF BIRTH: _____

PRIMARY PARENT / LEGAL GUARDIAN NAME: _____

ADDRESS: _____

TELEPHONE: _____ ***RELATIONSHIP:** _____

***ATTACH COPY OF PHOTO ID (if one is not already on-file).**

SECONDARY PARENT / LEGAL GUARDIAN NAME: _____

ADDRESS: _____

TELEPHONE: _____ ***RELATIONSHIP:** _____

***ATTACH COPY OF PHOTO ID (if one is not already on-file).**

CONSENT ACKNOWLEDGEMENT:

I/we understand that minors are required to be accompanied by a parent or other legal guardian on each visit. I/we understand that, without a signed consent, ***The Hand & Wrist Center*** cannot provide consultation or treatment to a minor if their parent or legal guardian are not present. I/we acknowledge that on my/our behalf, neither is available to accompany my/our minor to the Center.

I/we hereby give my/our "Consent" for ***Ross Nathan, M.D., Kourosh M. Kolahi, M.D.*** and the Staff at ***The Hand & Wrist Center*** [collectively referred to as ***The Hand & Wrist Center***] to provide consulation and treatment to my/our minor, in my/our absence. Furthermore, I/we hereby release ***The Hand & Wrist Center*** from any liability that may occur, in relation to my/our minor, in my/our absence.

I/we deem this consent valid for the following duration:

____ **Today's visit only.**

____ **For the period / duration of care.**

My/our signature(s) below acknowledge(s) that the above-stated information is true and enforced immediately .

PARENT / LEGAL GUARDIAN SIGNATURE(S):

PRIMARY: _____ **DATE:** _____

SECONDARY: _____ **DATE:** _____

(HWC 11-01-23)