AUTHORITY TO TREAT A MINOR

____

Patient Name

I hereby authorize Ankle & Foot Clinic of Everett to care for the above named patient, and, after discussion and approval by me, to administer whatever therapy the doctor deems necessary or advisable in the diagnosis and treatment of this patient. I further acknowledge that I am financially responsible for all charges incurred.

____ ____

Parent or Guardian Name (Please Print) Parent or Guardian Signature

____ ____

Relationship Witness

____

DATE

Jeffrey C. Christensen, DPM*

Mary E. Crawford, DPM*

Cherie H. Johnson, DPM*

Jarrod A. Smith, DPM*

Robert L. Stanton, DPM

Physicians and Surgeons* of the Ankle & Foot Clinic's Northwest