



CORPORATE MEDICAL PLAZA
 BUILDING #1
 10701 NALL, SUITE 200
 OVERLAND PARK, KS 66211

PHONE: 913 / 381-KCBJ
 OR: 913 / 381-5225
 FAX: 913 / 901-0186
 WEBSITE: www.kcbj.com

CONSENT TO TREATMENT OF A MINOR

specializing in
 GENERAL ORTHOPAEDICS
 TOTAL JOINT SURGERY
 UPPER EXTREMITY SURGERY
 SPORTS MEDICINE

- HOWARD J. ELLFELDT, M.D.
- JAMES H. WHITAKER, M.D.
- ROBERT P. BRUCE, M.D.
- THOMAS S. SAMUELSON, M.D.
- GERALD R. MCNAMARA, M.D.
- JEFFREY W. SALIN, D.O.
- SUZANNE G. ELTON, M.D.
- J. CLINTON WALKER, M.D.

MICROVASCULAR SURGERY
 SURGERY OF THE HAND

- CHRISTINE CHO-JEN CHENG, M.D.
- SUZANNE G. ELTON, M.D.
- J. CLINTON WALKER, M.D.

PHYSICAL MEDICINE AND
 REHABILITATION

- ATUL T. PATEL, M.D.

EMERITUS

- LARRY D. CORDELL, M.D.
- LARRY F. GLASER, M.D.

I hereby authorize examination and treatment of _____, a minor patient, by the physicians of Kansas City Bone & Joint Clinic, Inc. and any assistants or designees deemed necessary by the physician. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as the results of treatments or examinations at this clinic.

 Signature of Patient or Parent/Guardian Relationship

 Date Witness

 Printed Name

 Street Address Home Phone Number

 City, State, Zip Work Phone Number

TELEPHONE/VERBAL CONSENT TO TREATMENT OF A MINOR

I, _____, an employee of Kansas City Bone & Joint
 (NAME)

Clinic, PA, have obtained verbal permission from _____,
 (NAME)

_____, for examination & treatment of
 (RELATIONSHIP)

_____, a minor, prior to any medical
 (PATIENT'S NAME)

services being performed. Date of verbal consent: _____