

CONSENT FOR TREATMENT OF A MINOR PATIENT

I, _____, PARENT OR LEGAL GUARDIAN OF

_____ GIVE ADVANCED THERAPY CENTER
(CHILD'S NAME)

PERMISSION TO PROVIDE THE TREATMENT AND CARE THAT DR. _____

PRESCRIBED FOR MY SON OR DAUGHTER WHO IS A MINOR. I AUTHORIZE

ADVANCED THERAPY CENTER TO PROVIDE TREATMENT TO _____
(CHILD'S NAME)

IN THE EVENT THAT I DO NOT ACCOMPANY MY CHILD OR AM NOT PRESENT AT

THE TIME SERVICES ARE RENDERED.

DATE: _____

SIGNED: _____
(PARENT OR LEGAL GUARDIAN)

DATE: _____

SIGNED: _____
(ADVANCED THERAPY CENTER STAFF)