



CONSENT TO TREAT A MINOR:

I (we) being the parents, guardian or custodian of the minor being:

Name: _____ DOB: _____

do hereby authorize, request, and direct this office, its doctors and staff to perform examinations, diagnostic X-rays, laboratory tests, and any treatment that in their judgment is deemed advisable or is required while said minor child is under care of this office's doctors and staff until legal age. All charges for service and care given to said minor child will be charged directly to me (us) and I (we) will be personally responsible for payment of them. I (we) hereby authorize the doctor to release all information necessary to secure payments of benefits. I authorized the use of this signature on all insurance submissions.

Parent/Guardian Name(Print): _____

Parent/Guardian Signature(X): _____ Date: _____