

CONSENT TO TREATMENT OF A MINOR

Minor's Name: _____ D.O.B. _____

I, the undersigned, attest that I am the custodial parent or legal guardian of the above-referenced minor ("the minor") and hereby authorize North Texas Orthopedics & Spine Center to administer treatment as it so deems necessary to the minor. This would include treatment by doctors, physician assistants (P.A.-C.), physical therapists (P.T.), physical therapy assistants (P.T.A.), X-ray technicians, and MRI technicians. In no event shall my signature to any other such document have any effect on this consent form.

Name of Custodial Parent/Legal Guardian (PRINT NAME): _____

Relationship to the Minor: _____

Custodial Parent Guardian by Law - Date Guardianship Commenced ____ / ____ / ____

Other (Please Specify): _____

Social Security # of Parent/Guardian: ____ - ____ - ____

Custodial Parent/Legal Guardian's Date of Birth: ____ / ____ / ____

Address of Parent/Legal Guardian: _____

Home Phone # of Parent/Legal Guardian: (____) ____ - ____

Work Phone # of Parent/Legal Guardian: (____) ____ - ____

The listed person(s) below has permission to bring (name of minor) for *follow-up or subsequent visits*.

Name: _____ Relationship: _____ ID: _____

Name: _____ Relationship: _____ ID: _____

Do we have your permission to?

Discuss and or coordinate the Patient's health information and treatment plan with other care providers, including Athletic Trainers, Coaches, and Physical Therapists.

Yes No Name of School: _____

My son/daughter is **16 years of age or older** and has my permission to be seen on *follow-up or subsequent visits* without parent/guardian attending.

Yes No

This authorization will **expire 1 year** from date signed.

Signature: _____ Date: ____ / ____ / ____

NTO Representative: _____

North Texas Orthopedics & Spine Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.