movement systems
physical therapy

Consent for Treatment of Minor

MINOR PATIENT: _____ DOB: _____

(Form to be completed by parent or guardian for any patients under the age of 18)

CONSENT FOR TREATMENT
I hereby authorize and consent to treatment upon my minor child being performed by Movement Systems Physical Therapy, P.S. with and without my presence. I further authorize the release of records to any insurance company or provider for purposes of payment, treating physician, and for other payment requirements or treatment purposes.

PAYMENT RESPONSIBILITY
It is herby understood and agreed that the undersigned and/or the patient will be personally responsible for all treatment which is furnished to the patient, which is not covered by insurance benefits. By signing this provision, you are expressly agreeing to person liability for all charges, which are incurred, regardless of benefits, which may be available. Movement Systems Physical Therapy, P.S. agrees to submit all charges for payment to
insurance carriers, if any. By signing this agreement, I hereby agree to be responsible for all charges incurred by the patient.

_____
Parent or Guardian Printed Name

_____
Parent or Guardian Signature

_____
Parent or Guardian Date