CONSENT TO TREATMENT OF A MINOR

Patient Name: _____ (print name of minor child)

I, the undersigned, attest that I am the custodial parent or legal guardian of the above-referenced minor ("the minor"), and hereby authorize Applied Healthcare Associates, P.S. to administer treatment as it so deems necessary to the minor. In the event that the minor has received treatment at this practice previous to the date of this consent form, I hereby authorize such treatment in addition to the treatment mentioned above. I further authorize the minor to complete and sign any documents at Applied Healthcare Associates, P.S. which are customarily completed and signed by patients at your practice as a condition to treatment, and such signature shall serve as my own. In no event shall my signature to any other such document have any effect on this consent form.

Name of Custodial Parent/Legal Guardian(please PRINT)_____

Relationship to the minor:

☐ Custodial Parent ☐ Adoptive parent with custody

☐ Guardian by Law. Date Guardianship Commenced: _____ / _____ /_____

☐ Other (please specify):_____

Social Security # of Parent/Guardian _____ - _____ - _____ Date of Birth: ____ / ____ / ____

Address of Parent/Guardian:_____

City_____ St_____ ZIP_____

Home Phone #: (_____)_____ Work Phone #: (____)_____

Parent/Guardian *Signature*:_____ Date: _____ / _____ / _____

Witness (if any) Witness' Name:_____

Witness' Signature:_____Date: _____/ _____/ _____