

## Consent to Treat Minor

By signing below, I hereby give my consent to OSR Physical Therapy to evaluate and treat the following minor child:

Child's Name \_\_\_\_\_

Child's Date of Birth \_\_\_\_\_

Relationship to Child \_\_\_\_\_

PLEASE NOTE: OSR Physical Therapy strongly encourages parent or legal guardian participation in the Initial Evaluation Appointment. In this appointment, the PT will establish the plan of care and review, in detail, the necessary treatment components of the plan of care, including the frequency and duration of visits. It is important for both the patient and the patient's parent(s)/guardian(s) to understand the treatment being provided and to provide informed consent to the specified treatment plan.

I understand the above noted description of the Initial Evaluation Appointment and recognize the importance of attending this appointment with my minor child. If I am unable to attend, I will accept responsibility to contact the evaluating physical therapist directly with any questions or concerns related to the evaluation or specified treatment.

Printed name of parent or legal guardian \_\_\_\_\_

Signature of parent or legal guardian \_\_\_\_\_

Date \_\_\_\_\_

Phone number of parent or legal guardian \_\_\_\_\_

Email address of parent or legal guardian \_\_\_\_\_