



Locations in:
ANTHEM | NORTH PHOENIX
PEORIA | GILBERT | SCOTTSDALE
GLENDALE | SUN CITY
www.osrphysicaltherapy.com

Consent to Treat Minors

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 _____