



PREMIER
sports and spine center

Minor Consent Form For Treatment

I the parent, guardian, or authorized representative of the minor _____, Date of Birth ____ / ____ / ____, hereby authorize the doctors and staff to perform examinations, diagnostic imaging, and treatment that is deemed advisable or necessary while the minor is under the care of Premier Sports and Spine Center. All charges for services and healthcare given to the minor will be charged directly to me and I will be personally responsible for payment. I authorize the doctor to release all medical information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions and/or requests pertaining to the minor's medical condition, including but not limited to all records, reports, progress notes, diagnostic imaging reports and other medical tests and opinions.

_____ Date ____ / ____ / ____

Signature of Authorized Representative to Minor

Relationship of Authorized Representative to Minor