Authorization and Consent to Assess and Treat a Minor

Date: ____/____/____

Student Name: _____

Student Birth Date: ____/____/____

Check One:

_____ The undersigned does hereby authorize Synergy Physical Therapy and Sports Medicine consent to ONLY exam/assess the above mentioned minor by employees of Synergy Physical Therapy and Sports Medicine without a parent or guardian present.

_____ The undersigned does hereby authorize Synergy Physical Therapy and Sports Medicine consent to exam/assess AND treat the above mentioned minor by employees of Synergy Physical Therapy and Sports Medicine without a parent or guardian present.

I am aware I am responsible to provide you with the correct insurance information needed to process my child's bills. If I fail to do so, or provide false or out of date information, I will be held financially responsible. I am also aware that I am responsible for any copayment due at the time of visit based on my insurance.

Parent/Guardian's Signature: _____

Print Name of Parent/Guardian: _____

Relationship to Student: _____

Insurance Information:

Insurance Provider: _____

Policy Holder:_____ DOB:_____

Group #:_____ Subscriber ID: _____

SYNERGY
PHYSICAL THERAPY & SPORTS MEDICINE

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419 Park St. Sheffield, IA Ph. (641)892-4111
820 Sawyer Dr. Osage, IA Ph. (641)832-2955
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