RIDGEFIELD PHYSICAL THERAPY
CONSENT FORM TO TREAT MINORS

Date:_____

Patient Name:_____

Date of Birth:_____

I,_____, parent or legal guardian of _____, hereby:

- ❑ Grant authorization for the above minor to be seen, without my presence at this visit and throughout the duration of care.
- ❑ Grant authorization for the above minor to be seen, without my presence however with the accompaniment of _____(designated person)_____(relationship).

In case of an emergency, Ridgefield Physical Therapy should contact:

Name:_____

Relationship:_____

Phone:_____

I accept financial responsibility for the above minor throughout the duration of care.

Signed By:_____
(Parent or Guardian Signature)