Specialized Physical Therapy
Moving You Forward

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SPT Consent for Minor: Physical Therapy Treatment Form Page 1/1

Welcome to our practice and thank you for choosing Specialized Physical Therapy (**SPT**) for your premium Physical Therapy (**PT**) Services. We are passionate about our practice and committed to providing you and your family with the highest quality of care. We look forward to the opportunity to restore your health to its maximum potential. If you have *any questions or concerns*, please call our clinic and our staff will be happy to assist you.

*Please complete this form if your child is **under** the age of Eighteen (18) years.
If your child reaches the age of Eighteen (18) years anytime during treatment, the U.S. Federal Health Insurance Portability and Accountability Act (HIPAA) dictates that a parent or legal guardian sign a **HIPAA release form (available upon request at our clinic) in order for SPT to release any private information regarding an adult, **regardless** of who pays for our services.

I, (**PARENT OR LEGAL GUARDIAN of Patient** – *Please Print or Type Name*) _____ hereby authorize Specialized Physical Therapy, LLC to administer reasonable and standard physical therapy evaluations, techniques, manipulations, and treatments to my son or daughter, (**THE PATIENT UNDER EIGHTEEN (18) YEARS** of age and who will receive treatment at SPT – *Please Print or Type Name*) _____, who is a minor, even if I am not present. This professional care will be necessary to successfully treat any injuries or ailments the patient may have. In the event of an emergency, and since the patient is a minor, I hereby give my permission and consent to Specialized Physical Therapy, LLC to administer emergency care as needed and hold SPT harmless in their act of good faith.

Parent or Legal Guardian Contact Information:

Legal Address: _____ City: _____

Zip Code: _____ State: _____ Address Matches State License: Y ☐ N ☐

Valid Email Address: _____ Phone Number: _____

The patient or parent/legal guardian must provide **ACCURATE, TRUE, COMPLETE, and TIMELY** insurance, billing, third party, and health history information, determine whether our services are covered under your insurance plan, and ensure all insurance, attorney, and third party requirements are met for your plan prior to and throughout treatment. By signing your name on page one of this document and choosing Specialized Physical Therapy, LLC for physical therapy treatment, the patient or parent/legal guardian **certifies** that the *undersigned* **has read, fully understands, and agrees** with all company terms, is ALWAYS primarily liable for any and all unpaid account balances for services rendered, and agrees to pay account balances in full when due; furthermore, if insurance (i.e. health, auto, or workers' compensation) rather than cash is chosen for payment and claims have been fully or partially rejected, denied, or unpaid for **ANY REASON**, the patient or parent/legal guardian agrees to pay IN FULL for services rendered. Policy for patients considered minors (UNDER 18 YEARS OLD): The parent/legal guardian of a patient who is considered a minor is responsible for full payment.

PATIENT NAME (*Print or Type*): _____

PARENT or LEGAL GUARDIAN Name (*Print or Type*): _____

PATIENT or PARENT / LEGAL GUARDIAN **SIGNATURE**: _____ **Date:** _____