SOUTHWEST™ DIAGNOSTIC IMAGING CENTER

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

I, _____, am the parent/legal guardian or managing conservator of _____ a minor child, and am providing signed consent to diagnostic imaging exam(s) for the child. I am authorizing _____ an adult, to sign any and all required forms on my behalf. This individual is the child's _____.

I also agree to ensure any financial responsibility is satisfied at the time of service with the credit card information provided below or to make necessary financial arrangements with the Business Office within twenty-four (24) hours by calling (214) 345-2098.

Child's Name: _____

Child's DOB: _____/_____/_____

Insurance: _____

Policy #: _____

Group #: _____

Credit Card: _____

Credit Card #: _____

Name on Card: _____

Expiration Date: _____/_____ CVC#:_____/_____/_____ Zip: _____

Signed: _____

Print Name: _____

Signed on: _____/_____/_____

Telephone #: _____

Created 6/28/16