

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

l,		, am	the paren	it/legal guard	dian or managing o	conservator
of			_ a minor	child, and an	n providing signed	consent to
diagnostic imaging e	exam(s) for the child	. I am authoriz	zing			an adult,
to sign any and all re	quired forms on my	behalf. This ir	ndividual i	s the child's _		
I also agree to ensu	ire any financial res	ponsibility is	satisfied a	at the time o	f service with the	credit card
information provided	d below or to make	necessary fina	ancial arra	angements w	vith the Business (Office within
twenty-four (24) hou	urs 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 #:						