



ALISO VIEJO PHYSICAL THERAPY AND SPORTS MEDICINE

27432 ALISO CREEK ROAD, SUITE 100

ALISO VIEJO, CA 92656

(949)448-0872 TELEPHONE

(949)448-0984 FAX

Consent to Treatment of Minor Children

Patient Name: _____

Age on first visit: _____ years old

Diagnosis: _____

I (We) hereby authorize Aliso Viejo Physical Therapy and Sports Medicine to perform physical therapy treatment / procedures deemed necessary or advisable on the above listed minor child.

I (We) agree to hold Aliso Viejo Physical Therapy and Sports Medicine, and any of its employees or agents, free and harmless from any complaints, suits for damages or complications which may result from such physical therapy treatment / procedures.

Patient (if over the age of 14)

Date

Parent / Guardian

Date

Witness

Date