

Foot Healthcare Associates, P.C.

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CONSENT TO TREATMENT OF MINOR

NAME OF MINOR: _____

BIRTH DATE OF MINOR: _____

NAME OF PARENT/GUARDIAN: _____

I AM THE PARENT/GUARDIAN OF THE MINOR CHILD WHOSE NAME AND BIRTH DATE ARE INDICATED ABOVE. I HERBY GIVE PERMISSION TO DR. NEAL MOZEN AND ANY OTHER DOCTORS PRACTICING IN THIS OFFICE WITH DR. MOZEN TO EXAMINE AND TREAT THE ABOVE NAMED MINOR CHILD FROM THIS DATE FORWARD. THIS AUTHORIZATION IS VALID UNTIL REVOKED IN WRITING.

DATE

SIGNATURE OF PARENT/GUARDIAN

DATE

WITNESS