



CONSENT TO TREATMENT OF A MINOR

Minor's Name _____

Minor's Date of Birth: ___/___/___ Minor's Social Security # _____

I, the undersigned, attest that I am the custodial parent or legal guardian of the above-referenced minor, and hereby authorize **Lakeway Spine Center** to administer treatment as it so deems necessary to the minor. In the event that the minor has received treatment at **Lakeway Spine Center** previous to the date of this consent form, I hereby authorize such treatment in addition to treatment mentioned above. I further authorize the minor to complete and sign any documents at **Lakeway Spine Center** which are customarily completed and signed by patients at your practice as a condition to treatment, and such signature shall serve as my own. In no event shall my signature to any other such document have any effect on this consent form.

Name of Parent / Legal Guardian: _____

Address of Parent / Guardian: _____

Home Phone: (____) _____ Work Phone: (____) _____

Social Security # of Parent / Guardian: _____ Date of Birth: ___/___/___

Relationship to the minor:

- Custodial parent
- Adoptive parent with custody
- Guardian by Law Date Guardianship Commenced: ___/___/___
- Other (please specify) _____

Signature: _____ Date: ___/___/___

Witness (if any)

Witness Name: _____

Witness Signature: _____ Date: ___/___/___