Locust Grove Clinic, P.C.

835 Jackson Street
Locust Grove, GA 30248
770-898-0028

Consent to Treatment of a Minor

I, the undersigned, being the parent, legal guardian, or custodian of the minor child

_____, age_____,

do hereby authorize, request, and direct this office, its doctors and staff to perform examinations, diagnostic x-rays, laboratory tests, and any treatment that in their judgment is deemed advisable or is required while said minor child is under care of this office's doctors and staff, until legal age. All charges for service and care given to the above named minor child will be charged directly to me and I will be personally responsible for payment of them. I hereby authorize the doctor to release all information necessary to secure payments of benefits. I hereby authorize the use of this signature on all insurance submissions.

I also declare that I am the legal guardian of the above named minor child and have legal authority to consent to this treatment on behalf of the above named child.

_____
Print parent, guardian, or custodian name

_____ _____
Signature of parent, guardian or custodian Date