REGIONAL HEALTH GROUP, INC. Dba MSA

Consent & Request for Treatment of a Minor Child

As a parent or legal guardian, I hereby request treatment by MSA doctors, therapists, and/or staff of my minor child:

NAME: ______________________________

BIRTHDATE: _________________________

I understand that the treatment(s) given may involve orthopedic, physical therapy, and/or diagnostic services.
I also understand that I may discuss my child's care with his or her provider or MSA staff at any time.

I have read and understood the above information.

Signed: ______________________________ Date: _______
(Parent/Legal Guardian)

Relationship: _________________________

Witness: _____________________________ Date: _______