

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: _____