FLORIDA WEST COAST PHYSICAL THERAPY AND REHABILITATION CENTER, INC.

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Sarasota, FL 34243
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AUTHORIZATION TO TREAT A MINOR

I, _____ give Florida West Coast Physical Therapy and any personnel employed by same, full authority to treat my dependent child in my absence for any and all conditions which may require physical therapy during all visits to this office. I understand that all treatment will be provided under the referral of a licensed physician in accordance with Florida Law and by Licensed Physical Therapists. Therefore, I give _____, P.T., my permission to make any decisions he/she deems appropriate to carry out the treatment ordered for my child.

I have signed this release because I am unwilling or unable to accompany the child to the office and request Florida West Coast Physical Therapy to perform the treatment in my absence without any additional liability on it's part.

Furthermore, I agree to accept financial responsibility for the treatment rendered and will pay any bills incurred regardless of any applicable insurance coverage.

Parent Signature: _____ Date: _____

Witness Signature: _____ Date: _____