ATC Advanced Therapy Center
3475 Torrance Blvd, Suite B-2, Torrance CA, 90503 tel. 310-316-7748 fax 310-316-7648

CONSENT FOR TREATMENT OF A MINOR PATIENT

I, ____, PARENT OR LEGAL GUARDIAN OF

____ ____________ GIVE ADVANCED THERAPY CENTER
(CHILD'S NAME) (DOB)

PERMISSION TO PROVIDE THE TREATMENT AND CARE THAT DR.__________________________

PRESCRIBED FOR MY SON OR DAUGHTER WHO IS A MINOR. I AUTHORIZE

ADVANCEDTHERAPY CENTER TO PROVIDE TREATMENT TO ______________________________
(CHILD'S NAME)

IN THE EVENT THAT I DO NOT ACCOMPANY MY CHILD OR AM NOT PRESENT AT

THE TIME SERVICES ARE RENDERED.

____ ______________________
PATIENT NAME **DOB**

____ ______________________
SIGNATURE (Parent or Legal Guardian) **DATE**

SIGNED: _________________________ __________ **DATE:** ___________________
(ADVANCED THERAPY CENTER STAFF)