# SCHUSTER PHYSICAL THERAPY
# Consent for Minor Patient

**FINANCIAL POLICY**

At Schuster Physical Therapy we are pleased to treat patients of all ages. We understand that some of our minor patients are old enough to drive and may be attending appointments without the accompaniment of a parent or guardian, and that younger patients may be brought to their appointments by a trusted family member or friend. In order to ensure that we uphold our office policy of collecting payment at the time services are rendered, we require a credit/debit card to be placed on file in our billing system for each minor patient and the copay/coinsurance/deductible amount will be charged to the card on file at each appointment. This will also prevent you from getting a "surprise" statement at the end of your child's course of treatment and prevents any misunderstanding regarding the cost of your child's care.

I, _____, parent/guardian of _____, do hereby agree that the amount of $_____ will be charged to the credit/debit card number on file with Schuster Physical Therapy at each of my child's appointment times. I understand that if after my insurance company remits payment there is a balance outstanding, I will be sent a statement detailing the charges and at that time, I may opt to send a check or I may authorize a final payment in the amount of the balance due. I understand that if at any time during my child's course of treatment the information pertaining to the card of file changes, it is my responsibility to notify Schuster Physical Therapy immediately. Any charges to a card that are declined will result in my child's appointment being rescheduled until the information has been updated.

**EMERGENCY MEDICAL ATTENTION CONSENT**

I, _____, parent/guardian of _____, do hereby agree that in the unlikely event my child requires emergency medical attention while attending an appointment unaccompanied by myself or another parent/guardian the staff or agents of Schuster Physical Therapy may seek such attention at their sole discretion. I understand that every effort will be made to contact me immediately, if possible and appropriate before treatment is rendered, however, the well-being of my child will be considered first and foremost. I agree that the cost of all treatment rendered will be my responsibility and it will be my responsibility to communicate regarding insurance benefits and payment with the rendering facility and/or physician. This authorization includes, but is not limited to, emergency transport, x-rays or other imaging, and any treatment that emergency personnel deems necessary and appropriate.

The following people have permission to accompany my child to his/her appointment and act in my place as a temporary guardian to my child while on the premises of Schuster Physical Therapy.

_____ (relationship) _____

_____ (relationship) _____

Parent/Guardian Signature:_____Date:_____