

# LOGAN PRIMARY CARE

## CONSENT TO TREAT (Minor)

This is to certify that on this date, I \_\_\_\_\_, as parent or guardian of \_\_\_\_\_, give my consent to Logan Primary Care Service Corp. and its medical staff to provide medical care and treatment to the above mentioned patient by a licensed nurse, physician assistant, or physician, within the guidelines of the state, for any injury or illness that should arise and require medical attention.

If said patient is covered by a health insurance policy, this information should be presented to the front desk.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Patient Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_