NEUROLOGY CONSULTANTS, P.C.

LEGAL GUARDIAN

AUTHORIZATION AND CONSENT FOR CONSULTATION, OFFICE VISITS, TREATMENT AND DIAGNOSTIC TESTING

Date: ____

Patient: ____

I am the legal guardian/parent of the above-named patient. I give permission and consent to consultation, all office visits, diagnostic testing, treatment, hospital admissions and referrals to other physicians or facilities deemed necessary by the treating physician at Neurology Consultants, P.C.
Phone (day) ________________________ (evening)__________________________
As legal guardian for the above-named patient, I will provide a copy of the court ordered papers naming me legal guardian of the above-named patient to be kept in his/her chart.

I understand that I am legally responsible for any charges incurred and will provide information regarding insurance.

Signed ___________________________________Relationship________________

Address ____

Witness ____

Pavilion II
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fax (563) 383-2672