Stillwater Spine & Sports Center, Inc.

Tye K. Le Duc, D.C.
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MINOR AUTHORIZATION

I, _____, being the parent, guardian, or custodian of the minor _____, age _____, do hereby authorize, request, and direct the doctors, providers and staff to perform examinations, diagnostic x- rays, tests, and any treatment that in their judgment is deemed advisable or is required while said minor is under care of Stillwater Spine & Sports Center, Inc. All charges for services and care given to said minor will be charged directly to myself and I will be personally responsible for payment of them. These charges and payment are subject to Stillwater Spine & Sports Center, Inc.'s PAYMENT POLICIES and PAYMENT OPTIONS, which I have received in separate documents and agree to abide by.

I hereby authorize the doctor, providers and staff of Stillwater Spine & Sports Center, Inc. to release all information necessary to secure payments of charges from any other applicable source. I authorize the use of this signature on all insurance submissions and/or requests pertaining to the said minor's physical condition, including, but not limited to, all records, reports, progress notes, reports of diagnostic tests, x-rays and/or medical opinions.

_____
Signature of Parent/Guardian

_____
Printed Name of Parent/Guardian

_____
Relationship to Minor

_____
Date