MARK CROUCH D.O.
Weight Control

CROUCH CLINIC
113 East Leslie
Hamilton, Texas 76531
Tel. 254-386-8149 FAX 254-386-3494

ANGELICA CLARK, PA-C
Weight Control

Consent to Treat Minor Patient

Name of Minor Patient:________________________________Age:____Birthdate:______________

Name of Parent or Parents:____

Address of Parents:____Phone :____________________

Name of Legal Guardian or conservator:____

Address of guardian or conservator:__________________________________Phone:________________

"I affirm that I am authorized to make medical decisions on behalf of the above named minor patient.

I authorize the Crouch Clinic, P.A. to provide medical treatment to the above named minor patient.

I understand that the nature of treatment to be provided includes but is not limited to treatment for weight control and medical conditions associated with overweight and obesity including the use of prescription appetite suppressant medications.

I understand the treatment is to begin on the date this authorization is signed.

This authorization remains in effect until revoked in writing by me."

Signature of person giving consent:_________________________________Date___________________

Printed Name of person giving consent:____

Address:____Phone:____________________

Relationship to patient:____

In case of emergency contact: Name:____

Phone:____