Brooklyn Body Works
Physical Therapy, P.C.
Sports & Orthopedic Rehabilitation

Parental Consent of Treatment

Patient Name: _____ Date: _____

Date of Birth: _____

Parent/ Legal Guardian's Name: _____

Phone Number: _____

I grant authorization and consent for _____ to receive
NAME OF UNDERAGED PATIENT
physical therapy treatment at BROOKLYN BODY WORKS PHYSICAL THERAPY, P.C. in the event that I am not able to accompany him/her.

Signature: _____

202 Union Avenue, Suite k. Brooklyn, NY 11211 • P. (718) 387-7420 • F. (718) 387-7421