PARENTAL CONTACT OF TREATMENT

PATIENT NAME	DATE OF BIRTH

PARENT/ GUARDIAN'S NAME	TELEPHONE NUMBER:

I GRANT AUTHORIZATION AND CONSENT FOR THE MINOR MENTIONED ABOVE TO RECEIVE PHYSICAL THERAPY TREATMENT AT *BROOKLYN BODY WORKS PHYSICAL THERAPY, PC* AND *BROOKLYN BODY WORKS PHYSICAL THERAPY & WELLNESS* IN THE EVENT THAT I AM NOT ABLE TO ACCOMPANY HIM/HER.

SIGNATURE: _____ DATE: _____

BROOKLYN BODY WORK PHYSICAL THERAPY, PC
202 UNION AVENUE, STE. K
BROOKLYN, NY 11211
P. (718) 387-7420 F. (718) 387-7421

BROOKLYN BODY WORKS PT & WELLNESS
101 N. 10TH STREET, STE 302
BROOKLYN, NY 11249
P. (718) 702-6105 F. (718) 702-8659