AUTHORIZATION FOR MINOR PATIENTS
UNDER 18 YEARS OF AGE

I authorize treatment of my minor child, _____, by Advanced Sleep Center and the physicians who practice there. I understand that as the parent/guardian presenting this minor for treatment, I am personally financially responsible for payment of the account, regardless of any divorce or legal arrangements or settlements.

I authorize Advanced Sleep Center, the doctors practicing at Advanced Sleep Center, and their staffs to act as my agent in helping me obtain payment from this minor's insurance companies.

I authorize use of this form on all insurance submissions.

I authorize release of information regarding all services rendered.

I understand it is my responsibility to obtain a referral from this minor's primary care physician (if required by the insurance company) and that if payment is not made because of my not having the referral; I am personally financially responsible for payment of the account.

I understand that, in the event of non-payment and this account is turned over to collections, I agree to pay for the cost of turning my account over to the collection agency equal to the balance plus an additional 40% of the balance, plus court costs.

I authorize a copy of this Authorization to be used in place for the original.

_____	_____	_____
Parent/ Guardian Signature	Parent/Guardian Printed Name	Date