

Consent to Treatment of Minor

In order to provide you the best possible chiropractic wellness care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

CONSENT

(I)(We), the undersigned, parent(s)/person having legal custody/legal guardianship of

_____, a minor, do hereby authorize
(Name of Minor)

_____ as agent(s) for the undersigned
(Name of Agent)

to consent to any x-ray, examination, and chiropractic diagnosis or treatment, which is deemed advisable by licensed chiropractor, be rendered under the general or special supervision of any licensed chiropractor.

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above described agent(s) to give specific consent to any and all such diagnosis and treatment which chiropractor, meeting the requirements of the authorization, may, in the exercise of his/her best judgment, deem advisable.

This authorization shall remain effective until _____, 20_____
(Month and Day) (Year)

unless sooner revoked in writing delivered to the agent(s) noted above.

Date: _____

Signature: _____

Circle relationship: Parent / legal guardian / person having legal custody

Signature: _____

Parent