Consent to Treatment of a Minor

I HEREBY AUTHORIZE:

DR. ________________________________, DC

AND WHOM EVER HE MAY DESIGNATE AS ASSISTANTS TO ADMINISTER CHIROPRACTIC CARE AS DEEMED NECESSARY AND TO BE FULLY RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED.

TO:

MY_______________________ (INDICATE RELATIONSHIP)

____
NAME OF MINOR

DATE: ____________________

SIGNATURE: _____________________________________
PARENT OR LEGAL GUARDIAN

WITNESS: _______________________________________

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