FAMILY CHIROPRACTIC ASSOCIATES

Consent to Treat a Minor

Full Name of Child _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

Parent / Guardian's Name _____ Relationship _____ phone _____

Parent / Guardian's Name _____ Relationship _____ phone _____

I hereby authorize the providers at Family Chiropractic Associates to examine and/or treat my child.

_____
Patient Name Printed

_____
Date

_____
Patient Signature

_____
Family Chiropractic Authorized Rep

_____
Personal Rep Printed

_____
Personal Rep Signature

_____
Personal rep's relationship to the patient.