Powell Chiropractic Clinic, Inc.

Dr. James P. Powell · Dr. James D. Powell · Dr. Robert Powell · Dr. Walter B. Null IV · Dr. Abbey M. Crouse

CONSENT OF TREATMENT FOR A MINOR/CHILD

I hereby authorize the doctors of Powell Chiropractic Clinic, Inc. to administer treatment as is deemed necessary to my child, _____Date of Birth _____
I also authorize Powell Chiropractic Clinic, Inc., to release any information they deem necessary regarding my child's treatment to said child's school if required.

Are you legally responsible for this child's health care? YES_____ NO_____

Name of responsible party _____

Address of responsible party _____

Telephone number(s) _____

Is this child covered by insurance that we will be billing? YES_____ NO_____

Are you the policy holder? (Financially responsible party) YES _____ NO _____

Name of financially responsible party _____

Address of financially responsible party _____

Telephone number(s) _____

_____
Legally responsible party

_____
Financially responsible party

_____ DATE _____
Staff Witness

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