Consent for Chiropractic Treatment of a Minor Child

Name of minor patient: ___________________________________ Date of Birth: _____________________

I certify that I am the parent and/or legal guardian of ____
(*Name of child*)

and I consent to the rendering of chiropractic care, including diagnostic procedures, x-rays and treatment given by the doctor of chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic.

This authorization:

☐ is effective on ______________________________.

☐ is effective from ____________________________ to ______________________________.

☐ is effective until revoked by me in writing.

Parent/Legal Guardian Contact Information:

Home phone number ______________________ Office phone number ______________________

Cell phone number _______________________ Other phone number ______________________

I reserve the right to revoke this authorization at any time by writing to the below-named physician.

Parent/Guardian Signature: ____

Chiropractic Caring For You, LLC

Edward Wade Richardson, DC

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