Integrated
Health & Wellness Centre

CONSENT TO TREAT MINOR

(Under the age of 18 years old)

Patient's Name (Child) _____ Birthdate: _____ Age: _____

Parent/ Legal Custody Guardian Name: _____

Address : _____

: _____

Telephone(s): Home : _____

Cell : _____

Work : _____

I, Custodial Parent/ Guardian Name **(Printed):** _____, the undersigned, being the parent and/or legal guardian and/or person having legal custody (custodial parent) of the above-referenced minor consent to and request that she / he be examined, evaluated and treated at this office within the scope of any duly licensed Doctor of Chiropractic (D.C.). Services rendered may include but are not limited to, applicable x-rays, examinations, evaluations, diagnoses, and treatment as indicated and / or recommended by and under the supervision of any licensed Doctor of Chiropractic or other qualified staff of Integrated Health & Wellness Centre.

As of today's date, I have the legal right to select and authorize health care service for the minor named above. This consent shall be valid from this date forward until this applicable medical case is resolved or withdrawn by the undersigned. If I withdraw this consent, I, the undersigned, understand that I am responsible for, and agree to pay any and all outstanding monies due for services rendered hereunder and understand that I must notify Integrated Health & Wellness Centre IN WRITING of my intent to withdraw consent.

Legal Custodial Parent /Guardian Name **(Printed):** _____

Legal Custody Parent / Guardian Name **(Signature):** _____

Legal Custody Parent / Guardian Signed **[Today's Date]:** _____

Witness: _____ _____ _____

Witness (Print Name) Witness (Signature) Date