CONSENT TO TREATMENT OF A MINOR

I HEREBY AUTHORIZE,
DR. GARY LATIMER, D.C. and/or **DR. MELISSA MCPARTLAND, D.C**. AND WHOMEVER HE OR SHE MAY DESIGNATE AS ASSISTANTS TO ADMINISTER CHIROPRACTIC CARE AS DEEMED NECESSARY AND TO BE FULLY RESPONSIBLE FOR PAYMENT OF ALL SERVICES ENDERED.

TO MY:_____________________________ (indicate relationship)

______________________________ ___________________

NAME OF MINOR **DATE**

SIGNATURE:____

PARENT OR LEGAL GUARDIAN

WITNESS:____