GILMER
CHIROPRACTIC
401 N Boone Street Johnson City, Tennessee 37604

CONSENT FOR CHIROPRACTIC TREATMENT OF A CHILD / MINOR

I _____, ▢ Mother ▢ Father ▢ Legal Guardian

of (name of minor) _____, DOB: ___ / ___ / _____

consent to the rendering of care, including diagnostic procedures, x-rays and treatment given by Dr Josh Gilmer, DC and whomever he may designate as his assistants.

I acknowledge that I am responsible for all reasonable charges in connection with care and treatment rendered during this period.

I have read this form and certify that I understand its contents. This consent may be rescinded in writing at any time.

_____ _____
Signature of Parent / Guardian Date Signed

_____ _____
Witness Date Signed