Authorization to treat a minor

I, the undersigned give my permission to treat this patient. I certify that I am the legal parent or guardian of the patient. I have not been coerced, and I freely give my consent for chiropractic examination, x-rays if necessary, diagnosis, treatment, and any other procedure that is deemed necessary, as outlined in the Informed Consent for Chiropractic Treatment document. If I have any questions regarding this consent, I will contact the provider. I acknowledge that I have a right to have a copy of this agreement. I understand that I may withdraw this consent at any time by doing so in writing.

BY CLICKING ON THE CHECKBOX BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.