

Douglas Chiropractic Center

CONSENT TO TREAT A MINOR

MINOR'S NAME (PRINT): _____

I hereby request and authorize Douglas Chiropractic Center or Dr. Bryan Douglas, D.C. to perform diagnostic tests and render chiropractic adjustments and other treatments/therapy (if needed) to (Minor's Name) _____.
This authorization extends to all office staff at Douglas Chiropractic Center.

As of this date, I have the legal right to select and authorize healthcare services for the minor named above. Also, I clearly understand and agree that I am personally responsible for payment of all fees charged by Douglas Chiropractic Center.

Guardian Signature: _____ Date: _____

Printed Name: _____

Relationship to Patient: _____