

TRILLIUM CHIROPRACTIC CONSENT TO TREAT A MINOR

MINOR PATIENTS' NAME: _____

The risks associated with exposure to ionization, and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor, and after careful consideration I do hereby request, and authorize _____, to perform imaging studies, and chiropractic adjustments, to my minor child, for whom I have the legal right to select, and authorize health care services on behalf of.

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse /former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way I will immediately notify this office.

Parent /Legal Guardian

Date

Witness

Date