PROSPORT+SPINE
CHIROPRACTIC • SPORTS REHAB • MASSAGE

CONSENT TO TREAT (MINOR)

Patient Name: ____________________________________

I hereby request and authorize ProSport+Spine to perform diagnostic tests and render chiropractic adjustments and other treatment modalities to my son/daughter. This authorization also extends to include radiographic examination at the doctor's discretion.

As of the date, I have legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required, unless a no-contact order is presented at time of visit. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

For children under the age of 16, Parents or Guardians, please be sure to be in the office ready for pick up 10 minutes prior to the appointment ending. In the event of an emergency, please call our office immediately and have your child remain in the lobby until you arrive.

Date: _________________________

____
Signature

Witness: _______________________

____
Printed Name

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Relationship to Patient