CONSENT TO TREAT MINOR

(Under the age of 18 years old)

Patient's Name _____ Birthdate: _____

Age: _____

Parent/ Guardian Name(s): _____

Telephone: _____

I, [print name], _____, the undersigned, being the parent and/or legal guardian of the above-referenced minor consent to and request that she / he be examined, evaluated and treated at this office within the scope of any duly licensed Doctor of Chiropractic (D.C.), Acupuncturist (L.Ac) or massage therapist. Services rendered may include but are not limited to, applicable examinations, evaluations, diagnoses, and treatment as indicated and / or recommended by and under the supervision of any licensed Doctor of Chiropractic or other qualified staff of Sage Health Chiropractic & Wellness Center.

This consent shall be valid from this date forward until this applicable medical case is resolved or withdrawn by the undersigned. If I withdraw this consent, I, the undersigned, understand that I am responsible for, and agree to pay any and all outstanding balances due for services rendered hereunder and understand that I must notify Sage Health Chiropractic & Wellness Center IN WRITING of my intent to withdraw consent.

_____

Signature of Parent or Legal Guardian

_____

Date