HARDINSBURG CHIROPRACTIC, P.S.C.

STEFAN CESARZ, D.C., D.A.B.F.P.

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CONSENT TO TREAT MINOR CHILD (05/2022)

I hereby request and authorize *Dr. Stefan Cesarz, D.C. and the staff at Hardinsburg Chiropractic* to perform a physical examination, diagnostic testing (including x-rays if necessary) and render treatment including Chiropractic adjustments and adjunctive therapy. As of this date, I have the legal right to select and authorize health care services for the minor child named below.

Name of Minor:_____

Minor's Date of Birth:_____

Printed Name of Parent or Legal Guardian:_____

Relationship to Minor:_____

Signature of Parent or Legal Guardian:_____

Today's Date:_____