DUBLIN FAMILY Chiropractic
6365 Shier Rings Rd., Ste. A, Dublin, OH 43016 p) 614.764.4001 f) 614.764.4002
www.dublinfamilychiropractic.com

Consent to Treat Minor Child/Children

I, _____, hereby authorize Dr. Jamie L. Berringer, and/or any chiropractic assistant at Dublin Family Chiropractic, to administer chiropractic care as deemed necessary for my _____.
(indicate relationship of minor)

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above described agent(s) to give specific consent to any and all such diagnosis and treatment which chiropractor, meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable.

Print Name of Minor(s)_____

Printed Name of Parent/ Guardian_____

_____ _____
Signature of Parent/Guardian Date