717 Commercial St.
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# CONSENT TO TREAT A MINOR

(Under the age of 18 years old)

Patient's Name: ___________________________________ Birthdate: _____________________
Age: ________

Parent/Guardian Name(s): __________________________________________________________

| Telephone(s): | Home: | ______________________________ |
|---|---|---|
| | Cell: | ______________________________ |
| | Work: | ______________________________ |
| | Employer: | ______________________________ |

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.). Services rendered may include but are not limited to, applicable x-rays, 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 Sunrice Chiropractic LLC.

This consent shall be valid from this date forward until this applicable medical case is resolved or withdrawn by the undersigned.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 Sunrice Chiropractic LLC IN WRITING of my intent to withdraw consent.

Signed [today's date]: ___________________

by: Parent: ______________________________________________________________________

Print Name: _____________________________________________________________________