THE CENTER FOR SPINE PAIN
CONSENT TO TREAT A MINOR

MINOR'S NAME:____
(PRINT)

I hereby request and authorize the Doctors at The Center for Spine Pain to perform diagnostic tests and render chiropractic adjustments and other treatment to (Minors Name)______________________________. This authorization also extends to all office staff members in administering therapy modalities under the Doctor's supervision.

As of this date, I have the legal right to select and authorize healthcare 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.

If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Date:____________________

____
Signature of Legal Guardian

____
Relationship to Patient

____
Witness Printed Name