Foresight Chiropractic Wellness Center
2915 E. Baseline Road, Ste. 126
Gilbert, AZ 85234 480-325-6977

CONSENT TO TREAT MINOR

(Under the age of 18 years old)

Patient's Name ______ ____________________ Age: ____________________ **Birthdate: ______________________**

Parent/ Guardian Name(s):

____

Telephone(s): Home: __________________________________
Cell: __________________________________

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 Foresight 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This consent shall be valid from this date forward until this applicable medical case is resolved or withdrawn by the undersigned.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 monies due for services rendered hereunder and understand that I must notify Foresight Chiropractic, LLC IN WRITING of my intent to withdraw consent.

SIGNED [today's date]: __________________________________

by: PARENT: ____

PRINT NAME: ____