Consent to Treat a Minor Child

Please read the following and sign below. Your signature signifies you have read, understand and agree to the following statements and give your consent for treatment of your minor child.

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the results of chiropractic tests, diagnosis, and analysis. The Chiropractic adjustments or other clinical procedures are usually beneficial and rarely cause severe problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor will not give any treatment or health care if she is aware that such care may be contra-indicated. It is the responsibility of the patient/patient's parent or legal guardian to make it known, or to learn through diagnostic procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. Your Doctor of Chiropractic is licensed and is available to work with other types of providers in your child's health care regime.

I know that I am responsible for, and agree to pay, all fees incurred at this office by my minor child. I understand that any insurance benefits that I may have, for my minor child, are a contracted arrangement between me and the insurance company. This office will be responsible for preparing notes, billing receipts, and informational reports as needed to aid in insurance payment/reimbursement. I realize that this office is not responsible to negotiate disputed benefits for me regarding my minor child.

I understand that if my child is accepted as a patient at The Wellness Spot, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved regarding chiropractic treatment will be explained to me upon my request. I am choosing for my child to be treated, for today and all future visits at this office, through the use of various types of chiropractic manipulations, diagnostic x-rays, and several types of physiologic modalities (physical therapy). I realize there is no guarantee of results and have been informed that some risks of treatment do exist. These risks could include, but are not limited to: sprains, dislocations, fractures, strokes, and disc injury. While I do expect my doctor to use her best judgment to choose the most appropriate care for my child's condition, I agree that the Doctor cannot foresee every possible complication or risk which could arise in my child's treatment.

My signature below authorizes the Doctors of The Wellness Spot to provide treatment as the doctors deem necessary for my child.

Child's full name:____

Sex: (please circle) M / F Birthdate: (mm/dd/yyyy) ____/_____/_________

Parent's Signature:___________________________________ Date:_______________________