



**MODERN**  
**CHIROPRACTIC**  
**CENTER**

**Dr. Robert Stein**  
9841 Pines Boulevard  
Pembroke Pines, FL 33024

**Consent to Treat Minor**

I hereby authorize the physicians of Modern Chiropractic Center and whomever they may designate as their assistants to administer treatment as he so deems necessary to my son/daughter or other \_\_\_\_\_.

Patient's Name \_\_\_\_\_

Signature of Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness: \_\_\_\_\_