DiSalvatore Chiropractic
1956 West Prospect Road Ashtabula, Ohio 44004
(440) 992-0160 (440) 998-0121(Fax)
www.disalvatorechiropractic.com

CONSENT TO TREATMENT MINOR

I hereby request and authorize the doctors at DiSalvatore Chiropractic to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter:_____

This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care 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 so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read ( ) or have read to me ( ) the informed consent document explaining the chiropractic adjustment and related treatment. I have discussed it with the doctors at DiSalvatore Chiropractic and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated:_____ **Dated:**_____

_____ _____
Patient's Name **Doctor's Name**

_____ _____
Signature **Signature**

_____
Signature of Parent or Guardian (if a minor)