CONSENT TO TREAT A MINOR

Patient Name: _____

Responsible Party's Name: _____

Address: _____

_____

Phone: _____

The undersigned hereby request and authorizes Nathan T. Broghammer D.C. to perform diagnostic tests (including x-rays, at the doctor's discretion) and render chiropractic adjustments and other treatments to

_____who is a minor child.

This authorization extends to other doctors and office staff members.

As of the date below, the undersigned states and avows that he/she has 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, the undersigned does hereby agree to notify the Doctor/Clinic as soon as is possible.

Signature: _____Date: _____

Printed Name: _____

Relationship to Patient: _____

Witness: _____