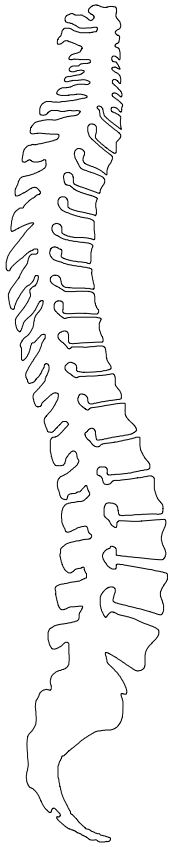
Balance your Health with Chiropractic

Synergy Chiropractic
Family Chiropractic Care • Sports Rehabilitation



CONSENT FOR TREATMENT OF A MINOR

Patient Name: _____ Date: _____

Date of Birth: _____

I hereby request and authorize SYNERGY CHIROPRACTIC OFFICE to perform diagnostic tests and administer chiropractic adjustments and other treatment as deemed necessary to my

_____, _____
son, daughter, etc. name

This authorization also extends to all doctors and assistants of Synergy Chiropractic Office 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 my authority to so select and authorize this care should be revoked or modified I will immediately notify this office.

_____ _____
Signature (Parent/Guardian) Date

_____
Print your name

_____
Relationship to Patient

_____
Witnessed By