Art of Life Chiropractic ~ Wellness

357 Hwy 74 N, Suite 1

Peachtree City, GA 30269

Consent to Treat Minor

(Under 18 Years Old)

Patient's Name: _____________________________________ Birth Date:________________________

Age: _______________

Parent / Guardian Names: ____________________________ Telephone: ________________ / ___________________

I, _________________________________, the undersigned, being the parent and / or legal guardian of the above referenced minor consent to and request that she / he be examined, evaluated and treated at this office within the scope of any duly licensed Doctor of Chiropractic (D.C.). Services rendered may include but are not limited to, applicable x-rays, examinations, evaluations, diagnoses, and treatment as indicated and / or recommended by and under the supervision of any licensed Doctor of Chiropractic or other qualified staff of Art of Life Chiropractic ~ Wellness.

This consent shall be valid from this date forward until this applicable medical case is resolved or withdrawn by the undersigned. If I withdraw this consent, I, the undersigned, understand that I am responsible for, and agree to pay any and all outstanding monies due for services rendered hereunder and understand that I must notify Art of Life Chiropractic ~ Wellness IN WRITING of my intent to withdraw consent.

SIGNED by said minor's Parent: _________________________________ Printed: ________________________________

Parent: _________________________________ Printed: ________________________________

On this date: ____