Murfreesboro Family Chiropractic Rehabilitation, PLLC.

Consent for Treatment of a Minor

Please Print

Patient Name _____ **D.O.B.** _____ **Date** _____

Responsible Party

If you are providing the information above for a patient under the age of 18 years old, please complete this section.

Child's Father's Name _____ SSN _____ DOB__ / __ / __

Father's Address (if different from above) _____
Street City State Zip Code

Father's Employer _____ Father's Work Phone ( ) _____

Child's Mother's Name _____ SSN _____ DOB__ / __ / __

Mother's Address (if different from above) _____
Street City State Zip Code

Mother's Employer _____ Mother's Work Phone ( ) _____

Please Note: It is the policy of this office that the parent accompanying the child for treatement will be held responsible for all bills. We cannot bill the other parent.

Consent for Treatment of a Minor

I hereby request and authorize Murfreesboro Family Chiropractic & Rehabilitation, PLLC to perform diagnostic tests and render chiropractic adjustments and other treatment to _____.

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.

Signed _____ **Date** ___/___/___

_____ _____
Printed Name Relationship to Patient