Murfreesboro Family Chiropractic Rehabilitation, PLLC.

Consent for Treatment of a Minor

Please Print

Father's Address (if different from above) Street City Father's Employer Child's Mother's Name SSN Mother's Address (if different from above)		Date	D.O.B	atient Name
Father's Address (if different from above) Street Father's Work Phone Child's Mother's Name Mother's Address (if different from above) Street City Mother's Employer Mother's Work Phone Please Note: It is the policy of this office that the parent accompanying the child for treatement or 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 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 (If applicable) Under the terms and conditions of my divorce, separation, or other legal authorization of a spouse/former spouse or other parent is not required. If my authority to so select and authorise should be revoked or modified in any way, I will immediately notify this office.		•		Responsible Party
Father's Employer Father's Work Phone	_DOB//_	SSND		Child's Father's Name
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Printed Name Relationship to Patien	tiont	Relationship to Patient		Printed Name