

ACE CHIROPRACTIC CLINIC

6770 W. Deer Valley Rd., #B-102, Glendale, AZ 85310 • Phone: (623) 362-1950 • Fax: (623) 572-2741

CONSENT TO TREAT MINOR

Patient Name _____

I hereby request and authorize **Dr. T. B. Peruch**, to perform diagnostic tests and render chiropractic adjustments and other treatments to **My Minor Son/Daughter:** _____.

This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of the 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.

Date

Signature

Witness

Printed Name

Relationship to Patient