**Parental Consent for Minor Care**

I certify that I'm the legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my child's condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by my child. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to my child will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my child's care or treatment.

Patient's Name: _____

Parent/Guardian Name:_____

Parent/Guardian Signature:_____