Case #: ____________

Back to Wellness Chiropractic

CONSENT TO TREAT A MINOR

I / We, the undersigned parent(s) and/or guardian(s) of ______________________________________ SS#: _____-_____-_____, a minor, do hereby authorize this office and its doctors to administer chiropractic care to my child, as they deem necessary.

____
Parent or legal guardians name (please print)

____
Parent or legal guardians signature

____
Witness's signature

____
Date

Agreement for Payment of Services

By signing the authorization above I affirm that I understand and agree that:

- health and accident insurance policies are an arrangement between patients and their insurance carriers:
- this office will prepare any necessary reports and forms to assist me in making collection from the insurance company;
- any amount that is authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse insurance payments to be applied to my account:
- all services rendered to me are charged directly to me and that I am personally responsible for the payment of my account; and
- it is the policy of this chiropractic office to collect for services as they are rendered, unless other financial arrangements are made,