KNOPP CHIROPRACTIC

Authorization for Medical Treatment of Minor Child

Patient Name: _________________________

I hereby request and authorize Knopp Chiropractic to perform diagnostic tests and to render chiropractic adjustments and other treatments to _____________________________, a minor child. This authorization also extends to all doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

By signing below, I hereby certify that as of the date hereof, 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, or guardian 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

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RELATIONSHIP TO PATIENT

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RESPONSIBLE PARTY INFORMATION

Parent or Guardian responsible for billing: ____

Billing Address: ____
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Billing Phone: ______________________________

Child's Address if different from responsible party's address: _____________________________________
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