



**253.638.2424**

13003 SE Kent Kangley Rd., Suite 110  
Kent, Washington 98030

# CONSENT TO TREATMENT (MINOR)

PATIENT NAME \_\_\_\_\_

I hereby request and authorize Pearson Chiropractic to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter. This authorization is intended to include radiographic examination at the doctor's discretion.

As of this 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 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