Bloom Chiropractic Center

1501 Riverwood Drive Suite 160
Burnsville, MN 55337
phone: 952-894-6300
fax: 952-894-2601

CONSENT TO TREAT MINOR

(Under the age of 18 years old)

Patient's Name _____

Birthdate: _____ Age: _____

Parent/ Guardian Name(s):

_____

Telephone(s): Home: _____ Cell(s): _____

Individuals Who May Bring Minor In For Treatment and Be Released PHI (other than parent/guardian):

Name: _____ Phone: _____

Relationship to Minor: _____

Name: _____ Phone: _____

Relationship to Minor: _____

I, [print name], _____, the undersigned, being the parent and/or legal guardian of the above-referenced minor consent to and request that she / he be examined, evaluated and treated at this office within the scope of any duly licensed Doctor of Chiropractic (D.C.). Services rendered may include but are not limited to, applicable x-rays, examinations, evaluations, diagnoses, and treatment as indicated and / or recommended by and under the supervision of any licensed Doctor of Chiropractic or other qualified staff of Bloom Chiropractic Center. I consent that any individuals listed above, are approved to bring the minor in for treatment. This consent shall be valid from this date forward until this applicable medical case is resolved or withdrawn by the undersigned. If I withdraw this consent, I, the undersigned, understand that I am responsible for, and agree to pay any and all outstanding monies due for services rendered hereunder and understand that I must notify Bloom Chiropractic Center IN WRITING of my intent to withdraw consent.

PARENT Printed Name: _____

PARENT Signature: _____

Date: _____