Goldi Jacques-Maynes, DC

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GOLDEN CHIROPRACTIC

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CONSENT TO TREAT MINOR

I hereby request and authorize Dr. Goldi Jacques-Maynes to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor child: _____.

This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of date, I have legal right to select and authorize health care services for th 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 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

_____

Relationship to Patient