Raef Chiropractic and Wellness
402 15th St
Canyon, TX 79015
Phone: (806) 655-1108

CONSENT TO TREATMENT OF A MINOR

Minor's Name: _____

I, the undersigned, attest that I am the custodial parent or legal guardian of the above-referenced minor ("the minor"), and hereby authorize Dr. Kevin E. Raef D.C. to administer treatment as it so deems necessary to the minor. In the event that the minor has received treatment at your practice previous to the date of the consent form, I hereby authorize such treatment in addition to the treatment mentioned above. I further authorize the minor to complete and sign any documents at Raef Chiropractic Clinic which are customarily completed and signed by patients at your practice as a condition to treatment, and such signature shall serve as my own. In no event shall my signature to any other such document have any effect on this consent form.

Name of Custodial Parent / Legal Guardian (please spell clearly): _____

Relationship to the minor:

☐Custodial Parent ☐Adoptive parent with custody

☐Guardian by Law Date Guardian Connected: _____/_____/_____

☐Other (please specify): _____

Social Security # of Parent/Guardian: _____ Date of Birth: _____/_____/_____

Address of Parent/Guardian: _____

_____

Home Phone #: (_____)_____ Work Phone #: (_____)_____

Signature: _____ Date: _____/_____/_____

Witness (if any)

Witness' Name: _____

Witness' Signature: _____ Date: _____/_____/_____