CONSENT FOR MEDICAL TREATMENT OF A MINOR

I hereby authorize Donald Littlejohn, DC and/or the staff at Chester Chiropractic Office to provide chiropractic care to my minor child, including, but not limited to, spinal manipulation, diagnostic examinations (including radiological testing), electric muscle stimulation, and ultrasound therapy.

I understand that health and accident policies are an arrangement between an insurance carrier and subscriber. Furthermore, I understand that all services rendered to my minor child are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my minor child's care and treatment, any fees for services rendered will be immediately due and payable.

I understand that, should my minor child need more extensive diagnostic procedures, I will be contacted before such care is initiated.

I further understand that, once my child reaches the age of majority, my consent for treatment is no longer required.

By signing this, I acknowledge that I have read and that I understand this consent, and that any questions I had prior to signing could be answered by calling Chester Chiropractic Office at 845-469-7575.

Name of Minor | Date of Birth

Address of Minor

City, State, Zip

Name of Guardian

Relationship to Minor

Address of Parent/Guardian

City, State, Zip

Emergency Contact Number | Alternate Contact Number

Signature of Guardian | Date

Witness | Date