

**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 this 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 Guardianship Commenced: \_\_\_/\_\_\_/\_\_\_
- 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: \_\_\_/\_\_\_/\_\_\_