HEIGHTS ATLAS ORTHOGONAL CHIROPRACTIC CLINIC, PA
3444 SE 6TH AVENUE, TOPEKA, KANSAS 66607
785-354-8909 FAX 785-354-8202

CONSENT TO TREAT MINOR

(Under the age of 18 years old)

Patient's Name _____

Birthdate: _____ Age: _____

Parent/ Guardian Name(s):

MOTHER: _____

FATHER: _____

GUARDIAN: _____

Telephone Numbers: Home: _____

Cell(s): _____

Work: _____

Employer: _____

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 Heights Atlas Orthogonal Chiropractic Clinic within the scope of any duly licensed Doctor of Chiropractic (D.C.).

I further consent to Services rendered which may include but are not limited to, applicable x-rays, examinations, evaluations, diagnostic procedures, diagnoses, consulting services, rendered in conjunction with chiropractic adjustments, treatments as indicated and/or recommended by and under the supervision of any licensed Doctor of Chiropractic or other qualified staff of HEIGHTS ATLAS ORTHOGONAL CHIROPRACTIC CLINIC, PA.

This consent shall be valid from this date forward until withdrawn by the undersigned.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 Heights Atlas Orthogonal Chiropractic Clinic, PA **IN WRITING** of my intent to withdraw consent.

SIGNED on this _____ day of _____, 20___.

PARENT OR GUARDIAN:

PRINT NAME: _____

SIGNATURE: _____

Agreement for Payment of Services:

By signing the authorization above I affirm that I understand and agree that:

- health and accident insurance policies are an arrangement between patients and their insurance carriers;
- any amount that is authorized to be paid directly to Heights Atlas Orthogonal Chiropractic Clinic, PA will be credited to my minor child's account upon receipt. I permit this office to endorse insurance payments to be applied to my minor child's account;
- all services rendered to my minor child are charged directly to me and that I am personally responsible for the payment of my minor child's account; and
- it is the policy of this chiropractic office to collect for services as they are rendered, unless other financial arrangements are made in advance.