

## CONSENT TO TREAT MINOR CHILD

I authorize the chiropractors of Heights Atlas Orthogonal Chiropractic Clinic, P.A. to perform chiropractic adjustments, treatments, and procedures of chiropractic to my child, \_\_\_\_\_.

I further consent to x-ray examinations, laboratory procedures, consulting services, and diagnostic procedures rendered in conjunction with the adjustments, treatments, and procedures, on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Print Parent/Guardian's Name

\_\_\_\_\_  
Signature of Parent/Guardian