Dr. Brittany Parlopino
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Consent for Chiropractic Treatment of a Minor Child

I, ____ the Mother/Father or Legal Guardian of ____ (minor) with the date of birth _________________________ consent to the rendering of care; including diagnostic procedures, examinations, imaging and treatment given by Dr. Brittany Parlopino. I acknowledge that I am responsible for all charges in connection with care and treatment rendered during this period.

I have read this form and certify that I understand the contents. This authorization is effective from ______________________________ to ______________________________.

Emergency Contact: ____

Relationship: ____ Phone: __________________________

Signature: ____ Date: ___________________________

Date: ___________________________

Witness Signature: __________________________________

Patient's Name: ____________________________________

Patient's Signature: _________________________________ Date: ___________________________