THE CHIROPRACTIC ZONE

Craig Weiner DC | 5405 Wilkinson Rd Langley WA 98260 | 360 331 5565

Authorization & Consent for Care of a Minor

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he deems appropriate.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all expenses incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I herby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

_____ _____

Patient Name (Please print): **Patient or Guardian Signature** **Date**

Consent for Treatment of a Minor (If applicable)

I/we, the undersigned, parent(s)/person having legal custody/legal guardianship of the above mentioned patient, a minor, do hereby authorize the Chiropractic Zone as agent(s) for the undersigned to consent to any examination and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, to be rendered under the general or special supervision of any licensed chiropractor. It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above-described agent(s) to give specific consent to any and all such diagnosis and treatment which chiropractor, meeting the requirements of this authorization, may, in the exercise of his best judgment, deem advisable. These authorizations shall remain effective until _____, 20___, unless sooner revoked in writing delivered to the agent(s) noted above.

_____ _____

Parent/Legal Guardian (Please print): **Parent/Legal Guardian Signature** **Date**

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Relationship to Patient