VERONA CHIROPRACTIC, LLC

413 WEST VERONA AVENUE, VERONA, WI 53593

608-497-3000

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize Dr. Tara Osterholz, D.C. and/or Dr. Lindsey Reitzner, D.C. to perform diagnostic tests and render chiropractic adjustments and other treatment to my:

SON/DAUGHTER:

_____

Child's name

This authorization also extends to all other doctors and office staff members and is intended to include radiographic examinations at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

_____ _____

Signature **Date**

_____

Printed Name