PRESCOTT CHIROPRACTIC

Dr. Carina Patnode, DC
Dr. Marisa Hamre, DC
Dr. Casey Webber, DC
1380 N Acres Rd Suite A
Prescott, WI 54021
P:715.262.8555
F: 715.262.8744

CONSENT TO TREATMENT OF MINOR

Today's Date: _____

Patient Name (First, MI, Last): _____

Date of Birth: ____/____/_____ Parent/Guardian: _____

Relationship to Patient: _____

Address: _____

City: _____ State :_____Zip: _____Phone: _____

List up to 3 Emergency Contacts (Name, Relationship, Phone Number):

_____

_____

_____

I hereby request and authorize Dr. Carina Patnode, D.C. and/or Dr. Marisa Anderson, D.C. and/or Dr. Casey Webber D.C. to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of the 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:_____