FLOCK
CHIROPRACTIC

INFORMED CONSENT TO TREAT A MINOR CHILD

Gail Y. Flock, D.C.
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Name of Patient: (Minor)	**Date:**

As parent or legal guardian of the minor child named above, I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy on the patient named above by Dr. Gail Y. Flock, D.C.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to her, is in the patient's best interest.

This authorization is effective from _____ to _____ .

_____ _____
Signature of Parent or Legal Guardian DOB

_____
Printed Name of Parent or Legal Guardian

_____
Signature of Witness

_____
Printed Name of Witness