True Balance Chiropractic, LLC
51669 Columbia River Hwy Suite 130
Scappoose, OR 97056
PH: 503-987-1696
F: 503-987-1152

Consent to Care of a Minor

Patient's Name: _____

Patient's Date of Birth: _____

I certify that I am the legal guardian of the patient above, and I give the health care providers at True Balance Chiropractic, LLC my permission and authority to provide care in accordance with all appropriate tests, diagnoses, analyses, and treatments indicated for his/her condition. I have been informed of the chiropractic treatment procedures, alternatives, and risks. The clinical procedures performed are usually beneficial and seldom have negative side effects. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. I certify that I have been honest and complete on all health history forms and when speaking with the practitioner. It is my responsibility to inform the provider of any and all current and past health conditions, injuries, and surgeries now and throughout the course of the treatment as new incidents may arise, even if they do not pertain to the areas of treatment. I also take full financial responsibility for the cost of care provided to my child/dependent.

I have read and understand the foregoing.

Print guardian name: _____

Guardian Signature: _____

Today's Date: _____

Relationship to the patient: _____