Susan Bosler D.C.

CONSENT TO TREAT A MINOR

I hereby authorize Dr.___________________________ and whomever he or she may designate as his/her assistants to administer treatment as he/she deems necessary to (name)___________________________.

Dated at SPINAL HEALTHCARE & PHYSICAL MEDICINE this ______day of _____________(month), 20________.

Parent or Guardian   Printed Name:_______________________________________

Signature:____

Custodial Parent/Guardian? ☐ Yes ☐ NO

WITNESSED____Date________________