PARENTAL CONSENT FOR MINOR PATIENT:

I HEREBY AUTHORIZE JOSEPH D. BAUDILLE, DC
AND WHOM EVER HE DESIGNATES AS ASSISTANTS TO ADMINISTER CHIROPRACTIC CARE AS DEEMED NECESSARY AND TO BE FULLY RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED.

Patient Name: _____

Patient Age: _____ **DOB:** _____

Printed name of person legally authorized to sign for Patient: _____

Signature: _____

Relationship to Patient: _____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for Patient: _____

Signature: _____

Relationship to Patient: _____

Remarks:

Parental Consent for Minor Patient