New Beginnings Chiropractic
Consent for Minors

Patient Name: _____

I hereby request and authorize **Dr. Brenda Trudell** to perform diagnostic tests and render chiropractic adjustments and other treatment to _____. This authorization also extends to all other doctors and office staff members.

I, the undersigned, do hereby request and consent to the performance of chiropractic treatment and related physical therapy procedures upon the above-named patient (my dependent). I wish to rely on the chiropractor to exercise judgment for my best interest during the course of treatment. I will inform the chiropractor or certified assistant who is treating my child of any sensitive areas or adverse conditions my child have had prior to, during, or after treatment. I intend this consent to cover the entire course of treatment. I recognize that the practice of chiropractic is not an exact science and I acknowledge that no guarantees have been made to me as to the result of services administered to my child in connection with this Agreement. I understand as with any health care procedure that certain complications my rarely occur such as fracture, disc injuries, muscle or vertebral strains, arterial dissection or others.

I understand payment is expected at the time of the visit. Any other arrangements, including direct insurance billing, payment plan or deferral, must be made in writing through the front desk. I realize a notice of 24 hours is encouraged for cancelled appointments. Therefore, canceling as early as possible is greatly appreciated to allow others the time slot.

I hereby authorize the release of my child's medical records and other information necessary to process insurance claims.

I clearly understand and agree that all services rendered to my dependent, the above-named patient, are charged directly to me and that I am personally responsible for payment. I understand that even if I suspend or terminate the treatment, any fees for professional services rendered to me will be immediately due and payable.

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.

Patient Name_____

Parent/Guardian Signature_____ Date_____