DR. SCOTT F. ALEY, DC

Santa Clara Chiropractic Center
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CONSENT TO TREAT MINOR

(Under the age of 18 years old)

Patient Name: _____ Birthdate: _____

Age: _____

Parent/Guardian: _____

Contact info: Home Phone: _____

Cell Phone: _____

Work Phone: _____

Employer: _____

I, _____, the ☐Mother ☐Father ☐Legal Guardian of

_____, the undersigned, being the parent and/or legal guardian of the above-referenced minor consent to and request that (s)he be examined, evaluated and treated at this office within the scope of any duly licensed Doctor of Chiropractic (DC). Services rendered may include but are not limited to, x-rays, examinations, evaluations, diagnoses, and treatment as indicated and/or recommended by and under the supervision of any licensed DC or other qualified staff of Santa Clara Chiropractic Center (SCCC).

This consent shall be valid from this date forward until this applicable medial case is resolved or withdrawn by the undersigned. If I choose to withdraw this consent I must notify SCCC in writing of my intent to withdraw consent. I, the undersigned, understand that I am responsible for and agree to pay any and all outstanding monies due for the services rendered hereunder.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Parent/Guardian Date