BALANCE CHIROPRACTIC, PLLC
14 SOUTH STREET
CONCORD, NH 03301
(603)224-5551

CONSENT FOR MINOR TREATMENT

I, ____________________________ hereby authorize treatment of my
(Parent or Legal Guardian-Please Print)

son/daughter, ____________________________, who is a minor. This treatment is on the
(print Minor's Name)

form of examinations, evaluations, manipulation and other accepted forms of physical medicine deemed necessary to completely resolve the injury/injuries for which my child is being treated.

____________________________________ ____________________________
Signature of Parent or Legal Guardian Date