



RAPP CHIROPRACTIC

Authorization for Evaluation and/or Treatment of a Minor Child Unaccompanied by a Parent or Legal Guardian

Patient Name: _____ Date of Birth: _____

Authorization for other individual to accompany minor patient under 18 years of age

I authorize _____ (Name of person(s) being authorized) _____ Relationship to Patient
To give consent to chiropractic treatments by Rapp Chiropractic on behalf of my child listed above. The above- named individuals may also receive additional information pertinent to the care and treatment of this minor child. I understand that I am still finically responsible for all expenses incurred by my child during these appointments. Valid until revoked in writing.
Parent/ Legal Guardian Print & Sign Date Signed
Phone number (in case of emergency/ updates on patient)

Authorization for minor patient to be unaccompanied for treatment by Rapp Chiropractic

I authorize and give consent for my child, listed above, to go independently to appointments and consent to all chiropractic treatment without the presence of a parent or legal guardian. I understand that I am still financially responsible for all chiropractic expenses incurred by my child during these appointments. Valid until revoked in writing.
Parent/ Legal Guardian Print & Sign Date Signed
Phone number (in case of emergency/ updates on patient)

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