CONSENT TO TREAT MINOR

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Child's Name: ____ Date of Birth: ____________________

I, ____, parent/legal guardian of above child do grant authorization and consent for above child to receive care at Synergy Health. Care may include medical, chiropractic, physical therapy, acupuncture, laser therapy, or massage therapy or any other care recommended or deemed necessary by the Synergy Health staff. I am financially responsible for any co-pays or charges incurred as a result of treatment (financial form and fee schedule available upon request).

Please check the following regarding financial responsibility:

I would like to receive a financial responsibility form prior to treatment: **Y N**

I would like to be notified prior to treatment of doctor recommendations.
If I am not available by phone at the time of appointment, care will not be provided until I give my verbal consent. **Y N**

Unless it is revoked sooner in writing, this consent remains in effect until my child:

Please select one: **18 Years Old** OR **Until _______/_______/20_____**

____ ______________________________

Printed Parent/Legal Guardian Name **Phone Number**

____ ______________________________

Printed Parent/Legal Guardian Signature **Date**