

BENNINGFIELD CHIROPRACTIC

2785 Charlotte Highway, Suite 23
Mooresville, North Carolina 28117
Phone (704) 799-8060 • Fax (704) 799-8131

PERMISSION TO TREAT A MINOR

I (we) the undersigned parent or legal guardian of _____, a minor, do hereby give permission to any consultation, examination, x-rays, and/or treatment provided by this office.

It is understood that this permission is being given in advance of any diagnosis being established and that effort will be made to inform the undersigned prior to rendering treatment to the patient, but that treatment will not be withheld if the undersigned cannot be reached.

List any restrictions:

Signature of Parent or Legal Guardian: _____ Date: _____