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**CONSENT FOR TREATMENT OF A MINOR**

By my signature, I hereby authorize Nadeau Chiropractic Associates to treat \_\_\_\_\_,

which includes, but is not limited to: examination, x-rays (if deemed necessary by the doctor), spinal adjustments and any adjunctive therapies the doctor deems necessary. I understand that by signing this form I the parent or guardian am financially responsible for any expenses incurred by my son/daughter at Nadeau Chiropractic Associates. I understand that the doctors will discuss my son/daughter's care with me. I further understand that this consent will remain in effect until the expiration date and if no expiration date is listed, this consent is open and non-ending.

Name of Parent/Guardian: \_\_\_\_\_

Signature of Parent/Guard: \_\_\_\_\_

Date: \_\_\_\_\_