



Authorization to Treat a Minor

I _____, (parent/legal guardian)
hereby request and authorize Advanced Sports Chiropractic to perform an examination as well as chiropractic care which may include the following: chiropractic adjustments, hot and cold therapy, and massage. I acknowledge that there is no guarantee or assurance of the results from the procedures provided by Advanced Sports Chiropractic. I also understand that on extremely rare occasion that there are some risks to examination and treatment, including, but not limited to; sprain, disc injury, dislocation, stroke or fracture. I intend for this consent to cover the entire course of treatment for the initial presenting condition and for any future condition(s) for which I seek treatment.

By signing below, I agree to the above named procedures.

I have read and understand the above statements.

Patient name (print) _____

Parent/legal guardian signature _____ Date _____

Doctor Signature _____ Date _____

360-647-1900

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Monday 8am-6pm, Wednesday/Thursday 8am-5:30pm, Friday 7:30am-11:30am
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