

1001 E BOGARD RD
WASILLA, AK 99654
907.376.2225 907.376.9225 FAX



CONSENT TO TREATMENT OF A MINOR CHILD

I hereby authorize licensed healthcare providers and their assistants to administer chiropractic care, physiotherapy, physical therapy and/or rehabilitation as deemed necessary to my: (circle one)

Son Daughter Other (explain)_____

Minor's Name: _____ Contact Phone: _____

Mother's Name: _____ Contact Phone: _____

Father's Name: _____ Contact Phone: _____

Legal Guardian: _____ Contact Phone: _____

I, as parent or legal guardian, remain financially responsible for any charges incurred, regardless of insurance coverage, or lack thereof. I understand that by signing this Consent to Treat Form, I agree to be the party responsible for payment, unless otherwise granted in writing. This applies even if the minor child is covered under another parent or guardian's insurance, as in the case of divorce/separation.

Dated at _____, Alaska
(city)

On the _____ day of _____ 20_____.

Signed: _____
(parent/guardian)

Spine and Sports Injury Center, LLC, 1001 E. Bogard Rd., Wasilla, AK 99654