CONSENT TO TREAT FORM

I, _____, authorize
(parent/guardian)
_____D.C., to evaluate and treat my
(doctor's name)
son/daughter, _____. I understand that the
(child's name)

care given at this office is not intended to diagnose and/or treat any disorders such as ADD, ADHD, Dyslexia, Autism, Autism Spectrum Disorders, or any other specific neurological developmental disorders; nor will myself or my insurance company be billed as such. Treatment will be that of evaluating and providing chiropractic care for the presence of vertebral subluxation of the spine, and, if necessary recommending various appropriate exercises to promote proper neurological function and/or development.

_____ _____
Signature of parent/guardian Date

_____ _____
Signature of Witness Date