Belleville Chiropractic and Wellness Center
PH: (608) 424 1840

1100 Bellwest Blvd
Belleville, WI 53508
Fax: (608) 424 1815

(MINOR) CONSENT TO TREATMENT

I hereby request and authorize Dr. Brad K. Freitag D.C. and/or Dr. Jay R. Makovec D.C. to perform diagnostic test and render chiropractic adjustments and other treatment to my child.

Childs name: _____

This authorization also extends to other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Date: _____ Relationship to patient: _____

Signature: _____ Print Name: _____