Griffin Chiropractic & Wellness Center, P.A.
4200 SW Green Oaks Blvd, Suite 100, Arlington, TX 76017
Phone: (817) 478-5800 Fax: (817) 478-5803

Consent to Treat a Minor

Patient Name:_____ Date:_____

I, _____, give my consent to **Griffin Chiropractic & Wellness Center, PA,** to examine and treat my child for any deficiency and to administer any treatment that is deemed necessary. I hereby signify acceptance of responsibility for payment of charges incurred by my child and understand that this agreement will remain in effect until the account is paid in full, even after my child reaches the age of majority. I also understand that insurance benefits may be applied and is acceptable as payment according to the guidelines of the policy of settlement and in conjunction with **Griffin Chiropractic & Wellness Center, PA**.

_____
Name of minor

_____
Name of Guardian

_____
Birthdate of minor

_____
Signature of Guardian

_____
Relationship to Minor

_____
Date