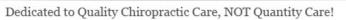


## DAVEN L. SPENCER, D.C.





## Consent to Treat a Minor Child

| Patient Name:   |   |
|---|---|
| I, as the parent or legal guardian, hereby req<br>perform diagnostic tests and render chiropra<br>therapies to:   | ctic adjustments and other supportive         |
| This authorization is extended to other staff radiographic examination at the doctor's disc   |   |
| As of this date, I have the legal right to select above named minor child.  | et and authorize health care services for the |
| (If Applicable) Under the terms and conditionauthorization, the consent of a spouse/forme my authority to so select and authorize this oway, I will immediately notify this office. | r spouse or other parent is not required. If  |
| Signature   | Date  |
| Printed Name  | Relationship to Patient                       |
| Office Staff  |   |