Dr. John R. Schmitt
Chiropractic Physician

Parental Consent to Treat Child Patient

As parent/guardian, I ________________________ hereby authorize the treatment of ___________________________ by Dr. John Schmitt. I understand that I will be responsible for supervising the follow up of care with regard to office care and any home instructions, and that I will be responsible for payment of bills arising from care of the patient.

Signed _____________________________ Date _______________

Title (mother, father, guardian) ______________________________

Witness _____________________________ Date _______________

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