BIG IDEA FAMILY CHIROPRACTIC
3450 Acworth Due West Rd., NW ▪ Suite 330 ▪ Kennesaw, GA 30144
678-574-5227 ▪ fax 678-574-5223

CONSENT TO TREATMENT OF MINOR CHILD

I _____, hereby authorize: Dr. Gomez, DC
(Parent's name)

And whomever she may designate as assistants to administer Chiropractic Care,

as deemed necessary to my _____.
(Indicate relationship of child)

_____
(Name of Child)

_____
(Date of Birth of Child)

The response your child gets from any treatment program is directly related to the commitment you and your child give to the program. Results will depend on the regularity of your appointment schedule. No statement should be interpreted to mean that we can "cure" your child.

NO GUARANTEE NOR ASSURANCE HAS BEEN MADE concerning results of the procedures. _____ Initials

Signed: _____ Date: _____
(Parent or Guardian)