Dr. John Cipriani, DC, President
Dr. Sarah Abbott, DC
Erin Cates, P.T.

Permission to Treat a Minor

Pain Relief & Wellness Center must receive permission from a child's parent or legal guardian before providing treatment for an injury or illness that is non-life threatening. This form gives us legal permission to treat your child in case you cannot accompany him/her to the office for treatment.

Please Note: A parent/legal guardian must attend a minor's first visit with a provider at Pain Relief & Wellness Center.

Patient's Name: _____

Patient's Date of Birth: _____ Today's Date:_____

[ ] Please initial here if you are authorizing the minor to seek and consent to treatment with no adult present.

I acknowledge that I am responsible for all reasonable charges in connection with the care and treatment rendered.

Please send your child with their insurance card and a method of payment for every visit.

If your child is not covered under a medical insurance policy, please send them with a method of payment to cover the 'Student Point of Service Discount.'

In case of an Emergency, I can be reached at:

Address:	
Home Phone:	
Work Phone:	
Other Contact Phone Number:	

Signature Parent/Guardian: _____Date:_____

Relationship to patient (documentation may be requested):_____

Witness Signature: _____ Date:_____