Trochim Family Chiropractic
60 Meadow View Avenue
Rocky Mount, VA 24151
Phone: (540) 483-1811
Fax: (540) 484-1538

Authorization for Minors

This is to certify that I, ____________________________, am the custodial parent of ____________________________________, who is a minor and is unemancipated. I acknowledge Trochim Family Chiropractic, through its agents and employees will render necessary chiropractic treatment to said child, and I hereby authorize said treatment to be rendered with full and complete understanding that I shall be fully responsible for the bill incurred by said child for such treatment.

Initial ____ I grant authorization for diagnosis and treatment only in my presence.

Initial ____ I grant authorization for diagnosis and treatment in either my presence or the presence of an authorized agent(s).

Authorized agents(s)

Name: _____________________ Relationship: __________________ Phone: _________

Name: _____________________ Relationship: __________________ Phone: _________

Name: _____________________ Relationship: __________________ Phone: _________

Initial ____ I authorize diagnosis and treatment of ________ when he/she is not accompanied by myself or an authorized agent.

Initial ____ Authorization of agent(s) also grants the power to the agent(s) to sign release of information forms when required by other healthcare providers.

Initial ____ Authorization of agent(s) also grants the power to the agent(s) to sign release of information forms when required by any third party payers who may be responsible for part or all of the cost of services provided.

_____/_____/______ ____

Date Signature of Parent, guardian or legal representative