Neal Wieder, DC, DCBCN
Chiropractic Physician – Diplomate in Clinical Nutrition
Certified in Acupuncture
1045 Primera Boulevard, Suite 1017
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CONSENT TO TREATMENT OF A MINOR CHILD

I hereby request and authorize Dr. Neal Wieder to administer to my dependent minor child as is medically necessary and at the doctor's discretion:

Chiropractic care, Exercise rehabilitation, Physiotherapy (electrical muscle stimulation, ultrasound, manual muscle therapy (myofascial release), traction or other modalities, Acupuncture, Cupping, Moxibustion, Laser Acupuncture, Laboratory testing to my dependent minor child, medically necessary X-rays, MRI studies, CT scans or other needed diagnostic studies.

CHILD'S NAME: ____

RELATIONSHIP TO CHILD: ____

As of today's date, I have the legal right to select and authorize health care services for the minor child name above.

If applicable, under the term's and conditions of my divorce. Separation or other legal authorization, the consent of a spouse, former spouse or other parent is not required to authorize treatment in this office. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

TODAY'S DATE: _____________________ CITY/STATE: ________________________

SIGNATURE PARENT/GUARDIAN: ____

PLEASE PRINT NAME:____

ADDRESS:____

_______________________________________PHONE: _________________

WITNESS:____