

Derek Rice D.C., LLC  
7500 W. Mississippi Ave. D2  
Lakewood, CO 80226  
(303) 922-7946

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CONSENT TO TREAT A MINOR

Minor's Name: \_\_\_\_\_  
(Please Print)

I hereby request and authorize Dr. Derek Rice, D.C. to perform diagnostic tests and render chiropractic adjustments and other treatment to (Minor's Name) \_\_\_\_\_ . This authorization also extends to all other doctors and office staff members and includes radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize healthcare service for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse, former spouse or other parent is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to Patient