<u>THE CHIROPRACTIC OFFICE</u>
JACKSON HIGHLEY, MA, DC
STEPHEN W. KONGS, DC
SEAN MARCELLA, DC
1420 King St, STE D, Bellingham, WA 98229
(360) 676-4488

Consent to Treatment of Minor Child

I hereby authorize Jackson Highley, MA, DC, Dr. Lisa M. Nelsen, PLLC, Stephen W. Kongs, DC, and/or Sean Marcella, DC and whomever they may designate as assistants to administer chiropractic care as deemed necessary to my:

___________________________________ ____
(indicate relationship ie. son/daughter) (Name of Minor Child)

Dated at Bellingham, Washington this _____ day of _______________________, 20____.

Patient Date of Birth ________________________________

Parent/Guardian Signature ____

Parent/Guardian Printed Name ____

Date _______________________

Witness Signature ____

Date _______________________