doctor FOR moms | perinatal & pediatric natural health center

Custodial Consent To Chiropractic Care Children aged 0-18

Do you have health care custodial rights of this child ? YES ☐ NO ☐

I/ We,_____& _____ being the parent (s)/

guardian (s) of _____, consent to him/her

receiving Chiropractic Care at Dr. For Moms Perinatal & Pediatric Natural Health Center.

I/We have had the opportunity to discuss and ask questions regarding the nature and purpose of this care with the doctor and/or the office staff.

I/We agree to be responsible for the payment of all fees charged by this clinic for care as rendered.

_____	_____
Print Parent/ Guardian Name	Print Parent/ Guardian Name
_____	_____
Signature of Parent/ Guardian	Signature of Parent/ Guardian
_____	_____
Date Signed	Date Signed