Keifer Wellness Center

Dr. John R. Keifer

Chiropractic Physician

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AUTHORIZATION FOR TREATMENT
AND
CONSENT TO TREATMENT OF A MINOR CHILD

I, the undersigned, a patient in this office, hereby authorize Dr. Keifer (and whomever he may designate as his assistants) to administer such treatment as is necessary, and to perform procedures as are considered therapeutically necessary on the basis of findings during the course of said treatment.

I hereby certify that I have read and fully understand the above authorization for treatments, the reasons why the procedures are considered necessary, its advantages and possible complications, if any, as well as possible alternative modes of treatment, which were explained to me by Dr. Keifer.

I also certify that no guarantee or assurance has been made as to the results that may be obtained. I also understand that if I'm not responding appropriately to care in a reasonable amount of time I will be referred out to assess underlying conditions that may not be revealed by standard testing in this clinic.

Signed:____________________________________ Date: _________________________

Witness: ___________________________________ or: ____________________________
(Nearest Relative)

FOR MY MINOR CHILD:

I hereby authorize Dr. Keifer and whomever he designates as his assistants to administer procedures as he so deems necessary to my minor child,

(name)____ .

Dated this _________ day of ________________________ , 20 ________ .

Signed: ____________________________________ Witness: ____________________________