Dane Roubos, D.C.
233 Fourth St, #3, Ashland, OR, 97520 (541) 821-3263

Consent to Treat Minor Child

The Information I have given this office is complete and true to the best of my knowledge. I authorize Dr. Dane Roubos, chiropractic physician, to provide appropriate evaluation and treatment to
(print minor's name) _____
as necessary.

I certify that I have authority and responsibility to authorize treatment for this child.

Parent's Signature _____ Date_____

Informed Consent

I understand that chiropractic care is extremely safe; however I also understand that certain risks are associated with any form of health care treatment.

I understand that chiropractic care is very safe, but there have been some cases of stroke associated with forceful medical or chiropractic adjustments of the upper neck. There is also some risk of fracture of ribs or other bones with forceful adjustments, more so in elderly patients. Even though Dr. Roubos uses the least amount of force possible, I understand that there is still some risk of injury.

I agree to communicate with Dr. Roubos as soon as possible if my child appears to be experiencing any confusing or adverse effects from his treatment, nutritional therapies he recommends, or home treatment procedures he prescribes.

Since Dr. Roubos addresses underlying factors, it is possible that they may experience some emotions coming up as a result of our sessions, and understand that this is a normal and healthy part of the healing process in certain cases.

I understand that certain risks are associated with any form of health care treatment. I accept these risks so that my child may receive treatment by Dr. Roubos, and agree to hold him harmless of any consequences thereof.

Print Parent's Name _____

Parent's Signature _____ Date_____