CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize:	
Dr	
and whomever he or she may designate as assistants to administer	
Chiropractic/ Medical care as dee	med necessary to
my	_(indicate relationship of child).
(name of child) Dated at(city)	on (state)
thisday of	,20
Signed:(Parents or Guardian)	
Witnessed:	

We use an innovative approach to Health Care Specializing in:

Dr. Chris Tsakalakis

Chiropractic Physician

Dr. John Sarantopoulos

Physiatrist

Dr. Effie Gatsinos

Chiropractic Physician

Dr. Ted Mikroulis

Clinic Director

Internal Medicine ~ Chiropractic ~ Massage Therapy ~ Acupuncture ~ Physical Therapy ~ Weight Loss Nutrition ~ X-Ray ~ Nerve Testing ~ Injections ~ MRI ~ Auto Accidents ~ Workman's Comp ~ Chronic Pain ~ Female Health