

PEEKS CHIROPRACTIC OFFICE

EDWARD J. PEEKS, D.C.

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Consent for Chiropractic Treatment of a Minor Child

I _____, the Mother Father Legal Guardian of

(Name of Minor) _____ Date of Birth: _____

consent to the rendering of care, including diagnostic procedures, x-rays and treatment given by
Dr. Edward J. Peeks and whomever he may designate as his assistants.

I acknowledge that I am responsible for all reasonable charges in connection with care and treatment
rendered during this period.

I have read this form and certify that I understand its contents. This consent may be rescinded in
writing at any time.

Signature: _____ Date: _____
Mother, Father or Legal Guardian

Witness: _____ Date: _____

Peeks Chiropractic, P.C.