



**Dr. Chad R. Kesner, DC, DACBSP, CCCN, CEDP**  
**Dr. Kimberly C. Kesner, DC, Dipl. Acup., CEDP**  
9299 South Broadway Suite 100  
Highlands Ranch, CO 80129  
303.683.3377

### **CONSENT TO TREAT A MINOR**

MINOR'S NAME (PRINT): \_\_\_\_\_

I hereby request and authorize Dr. Chad or Dr. Kim Kesner, D.C.'s to perform diagnostic tests and render chiropractic adjustments and other treatment to (Minor's Name)\_\_\_\_\_. This authorization also extends to all other doctors and office staff and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize healthcare services for the minor named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to Patient