



APPLIED HEALTHCARE
ASSOCIATES

Keith W. Morehouse, DC, CCEP
Justin M. Hamblet, DC
1403 S Grand 101 South
Spokane, WA 99203
509-838-2225

CONSENT TO TREAT A MINOR

Name of Minor: _____

Home Phone: _____ Cell Phone: _____

Address: _____

City, State, Zip: _____

Birth date: _____ SS#: _____

The above named individual is seeking treatment at this office. Since he/she is a minor, consent to treatment is required from a parent or legal guardian. Signature below acknowledges and authorizes such treatment.

“I am a parent or legal guardian of the above-named minor and I authorize Dr. Keith Morehouse/Dr. Justin Hamblet to conduct appropriate examinations of and administer appropriate treatment to him/her.”

Printed Name of Parent or Guardian

Parent or Guardian Signature

Date

Comments: _____
