



I do hereby authorize _____ and whomever he/she may designate as his/her assistant(s) to administer Acupuncture and/or Nutritional Care as he deems necessary to my child. I authorize this office to process all claims for said minor child as stated above and understand that any unpaid balance is my responsibility.

Date Patient/Guardian Name:

Printed Name Witness

SIGNATURE: _____ DATE: _____