



Atlas Spinal Care, P.C.

16500 SE 15th Street, Suite 160

(360) 718 - 7944

Vancouver, WA 98683

Fax (360) 718 - 7931

PARENTAL CONSENT FORM

Date _____

Patients Name (printed): _____ Date of Birth: _____

Legal Parent/Guardian Name (printed): _____ Date of Birth: _____

The above named patient, who is under eighteen years old, has permission to be seen by:

- () Chiropractic Doctor at Atlas Spinal Care
- () Licensed Massage Therapist at Atlas Spinal Care

Legal Parent/Guardian Signature: _____