HUGHES FAMILY CHIROPRACTIC
1039 MARKET ST
PARKERSBURG WV 26101

304 428 6900

COMPLETE IF PATIENT IS A MINOR:

_____
(print child's name)

I, _____, being the parent or legal guardian of the aforementioned child, have read and fully understand the "Terms of Acceptance" and hereby grant permission for my child to receive chiropractic care at Hughes Family Chiropractic.

_____ _____
(Signature) (Date)