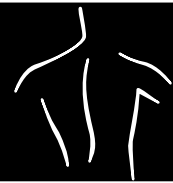


Palmer Chiropractic

Your health is our concern



I, (print your name) _____, as the parent or legal guardian of the above named minor, give to Dr. Thomas D. Palmer and his staff my permission to do the following listed and initialed procedures on the above named child.

- Perform a chiropractic examination. (Your initials please) _____
- Perform x-rays needed on this patient. (Your initials please) _____
- Initiate chiropractic care as deemed necessary. (Your initials please) _____

I understand that I am responsible for any portion of the bill not paid for by any health care coverage, including: private or group insurance, accident coverage, and any State or Federal health care program, etc.

Parent or Legal Guardian Signature _____

Child's Name _____

I, (print your name) _____, as the parent or legal guardian of the above named minor, give to Dr. Thomas D. Palmer and his staff my permission to do the following listed and initialed procedures on the above named child.

- Perform a chiropractic examination. (Your initials please) _____
- Perform x-rays needed on this patient. (Your initials please) _____
- Initiate chiropractic care as deemed necessary. (Your initials please) _____

I understand that I am responsible for any portion of the bill not paid for by any health care coverage, including: private or group insurance, accident coverage, and any State or Federal health care program, etc.

Parent or Legal Guardian Signature _____