JORDAN JACOBS, L.Ac, MAcOM. LE
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Authorization to Treat a Minor

I/We, _____ the undersigned parent, parents or legal guardian of _____(Minor's Name) authorize Jordan Jacobs, LAc to treat my/our child with acupuncture, moxibustion, cupping, moving cupping, electrical stimulation, Tui-Na (Chinese Massage), Chinese or Western herbal medicine, supplement recommendations, and/or nutritional counseling. It is understood that this authorization is given in advance of any specific diagnosis or treatment being rendered.

Under the circumstances set forth above, I elect not to be informed in advance of the nature and character of the proposed treatment, its anticipated results, possible alternatives, and the risks, complications and anticipated benefits involved in the proposed treatment, including non-treatment.

I further understand that the practitioner attending to my child will take all reasonable safety precautions during their care.

I also hereby agree to be responsible for all bills incurred by the aforementioned minor. I agree to pay these bills in a manner set forth by Jordan Jacobs, LAc.

This consent expires upon the patient's 18th birthday.

By signing this, I acknowledge that I have read and that I understand this consent, and that any questions I had prior to signing could be answered by calling Jordan Jacobs, LAc at 512-337-2588.

Signature of Parent(s)/Legal Guardian _____ Date _____

Provider's Signature _____ Date _____