Consent For Treatment

I hereby authorize Family Health and Wellness Center; including physicians and medical assistants, to provide to me appropriate routine medical care and treatment. I understand that by not signing this form I will not receive treatment from the physician.

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Signature Date

If Patient is a minor:
As the patients parent/legal guardian I have read and understand the above agreement for the treatment of my child.

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Patients First & Last Name. Date

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Relationship to child (Parent or Legal Guardian Signature)