Family Health
and Wellness Center

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.

_____

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.

_____

Patients First & Last Name. Date

_____

Relationship to child (Parent or Legal Guardian Signature)