
## Consent to Treat Form

I _____(patient name) give permission for Holistic Wellness to give me medical treatment.

I understand:

- I may need additional medical treatment such as blood work, imaging or prescriptions and will be fully responsible for entire cost.

I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my clinician.

Patient's Signature _____Date_____

Parent or Guardian Signature_____ Date_____

Print name_____ Date _____