

Consent To Treatment

I, undersigned, hereby authorize Wellbeing Medical Centre, (and / or any associate or assistant involved in my care) to treat my condition(s), and fully understand that there is:

1. No promise or stated guarantee has been made as to result or cure.
2. I have been informed that there may be significant risks, such as bleeding, bruising, fainting, drowsiness, and other consequences, which can result from any procedure.
3. I agree to hold free of any claims, demands, and / or actions from my participation in acupuncture, massage, and other therapy procedures.

I certify that the information I have reported with regard to my insurance coverage and confidential patient fact sheet.

Patient Name:..... Date:

Patient's Signature:

Provider's name:..... Date:

Provider's Signature:

If patient is a minor, unable to sign or incompetent to give consent, relationship of person authorized to give consent must be noted.

Name (Parent or Guardian):..... Relationship:

Signature: (Parent or Guardian):..... Date: