Consent for Treatment

1. I _____ (patient name) give permission for 830 Wellness to give me medical treatment.
2. I allow 830 Wellness to file for insurance benefits to pay for the care I receive.
3. I understand that:
    - 830 Wellness will have to send my medical record information to my insurance company.
    - I must pay my share of the costs.
    - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.
4. 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

(for children under 18)

Print name Date

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