Live Well
Medical Care

CONSENT TO TREATMENT

I voluntarily give my permission to the health care provider of Live Well Medical Care PLLC and such assistants as they may deem necessary to provide medical care services to me. I understand that by signing this form, I am authorizing them to treat me as long as I seek care from Live Well Medical Care, or until I withdraw my consent.

Signature of Patient or Guardian Date

Printed Name of Patient or Guardian Relationship to Patient

Witness Signature Date

A duplicate or faxed copy of this form is considered the same as the original document.