HOUSE OF WELLNESS

PATIENT CONSENT TO TREAT

I hereby give my consent to House of Wellness and authorize the providers and medical associates to provide my medical treatment. I understand that House of Wellness will explain my condition(s), foreseeable risks, and methods of treatment for my condition before treatment is provided. I authorize House of Wellness to perform any additional or different treatment that is thought necessary if, in an emergency situation, a condition is discovered that was not known previously.

I have carefully read, and I fully understand this Patient Consent to Treat form and have had the opportunity to discuss my condition and the above procedure(s) with the care provider. All my questions have been adequately answered.

CONFIDENTIALITY

I understand House of Wellness is committed to the confidentiality of communication with patients. Services provided by House of Wellness, information I disclose are confidential except as required by state or federal regulation. Personal information I have disclosed may be entered into my clinical records in written form.

_____ _____

Patient/legal Guardian's Signature Date

_____ _____

Printed Name of Patient/Legal Guardian Witness