INTENTIONAL HEALTH CLINIC
1785 NE Sandy Blvd., Suite 290, Portland, OR 97232

Consent to Treatment

The treatment and therapies rendered or recommended by our clinic may be different than those usually offered by a medical doctor or other licensed health care provider.
_____ **(Initials)**

As a patient, I have the right to be informed about my health condition(s) and recommended treatment. I have had the opportunity to discuss the potential benefits, risks and hazards involved as well as other treatment options available to me.
_____ **(Initials)**

I, _____, do hereby give my consent to services rendered and provided to me (or the patient named below, for whom I am legally responsible) as a patient at Intentional Health Clinic. I understand that patient care is directed by licensed healthcare providers and I consent to services rendered and provided to me by these professionals.

I have fully read and understand the above agreements and authorizations.

To attest to my consent, I hereby affix my signature to this authorization for treatment.

_____ _____
Patient's Name (print) **Date**

_____ _____
Patient's Signature **Date of Birth**

Consent to Treatment of a Minor Child

I, _____, being the parent/legal guardian/personal representative of _____ have read and fully understand the above informed consent and hereby grant permission for my child to receive treatment at Intentional Health Clinic.

_____ _____
Guardian/Representative Signature **Date**