



CONSENT TO TREAT:

I am the parent or legal guardian for the patient(s) listed below and am on the patient(s) behalf, hereby request and consent to the children listed below, to be examined and treated by the medical, nursing and other healthcare personnel who may participate in the patient's care. I understand treatment and services may include:

- Physical Examination
- History intake
- Recommendation of further evaluation or treatment from another provider/testing (includes vaccinations)

(Initial)

I have received or reviewed a copy of Well- Rooted Pediatrics Notice of Privacy Practices (HIPPA).

(Initial)

Child/Children(s) Name:

Date: _____