Consent for Treatment

I give my consent to receive treatment and related services from The Columbus Wellness Center & Affiliates.

_____. I understand that this consent is for the

duration of the services provided.

Client Name (please print): _____

Client Signature: _____

Date: _____

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Minor Consent to Treat

I give my consent as parent of guardian for the following individual to receive treatment and related

services from [Practitioner name] _____.

I understand that this consent is for the duration of the services provided.

Client Name [please print]: _____

Parent or Guardian Name [please print]: _____

Parent or Guardian Signature: _____

Date: _____