NW PEDIATRICS

INTEGRATIVE MEDICINE

CONSENT FOR TREATMENT

HEALTH CARE CONSENT: I request and agree to receive all services provided by the professionals authorized to care for me at with NW Pediatrics Integrative Medicine, LLC ("NWPIM"). NWPIM provides healthcare services to pediatric patients.

I understand these services may include:

- Services provided by nurse practitioners and other authorized health care professionals.
- Assessment, evaluation and treatment of medical diagnoses.

I ALSO UNDERSTAND:

- There may be risks and alternatives to a particular treatment or procedure my health care provider recommends.
- My provider may need to explain and discuss certain treatments or procedures. It is important for me to ask questions or ask for more information about the care or treatment I may receive with NWPIM.

I UNDERSTAND THAT I HAVE NOT RECEIVED ANY PROMISES OR GUARANTEES ABOUT THE RESULTS I MAY EXPECT FROM MY CARE WITH NWPIM. I HAVE READ AND UNDERSTOOD THIS CONSENT AND HAVE HAD THE OPPORTUNITY FOR MY QUESTIONS TO BE ANSWERED. BY SIGNING BELOW, I AM PROVIDING CONSENT TO MEDICAL TREATMENT BY NWPIM.

Patient Name: ____ DOB: ___________

Signature: ____ Date:_________________
(Parent/Guardian, Patient 14+ years old, or Personal Representative)

Printed name of signer: _____________________________________

Relationship to patient: _____________________________________