2146 NE 4TH Street #160 Bend, OR 97701
541-306-4471 phone | 541-566-7493 fax
ElixirBend.com

CONSENT FOR TREATMENT

By signing below, I am requesting Elixir: A Wellness Collective to provide health care related treatment and consultation to the below named patient and that I may refuse treatment or services at any time. I understand Elixir does not guarantee any outcome for any services or treatments, either stated or implied. I understand that licensed contractors of Elixir direct patient care.

______________________________ SIGNATURE OF PATIENT

______________________________ PRINT PATIENT’S NAME

______________________________ DATE OF BIRTH

__________________ DATE

CONSENT TO TREATMENT OF A MINOR CHILD

I, ______________________________________, being the parent/legal guardian of ______________________________ have read and fully understand the above financial policy, privacy practices, office policies, and informed consent and hereby grant permission for my child to receive treatment at Elixir.

______________________________ SIGNATURE OF LEGAL GUARDIAN

______________________________ PRINT PATIENT’S NAME

____________________________ PRINT NAME OF LEGAL GUARDIAN

__________________ DATE