Consent to Treat a Minor

I hereby authorize Elixia Wellness Group and its practitioners to administer treatment of my child in accordance with his/her treatment plan and within the scope of each practitioner's license.

I understand I am fully responsible for all charges incurred whether or not covered by insurance or a non-custodial parent.

Patient's Name
(Minor)_____

Signature (Parent or Legal
Guardian)_____

Date_____
_____

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