# CONSENT TO TREAT

1. I _____ (patient name) give permission for provider at The Mehra Clinic, PLLC to give my child an evaluation an medication treatment as needed.

2. **I UNDERSTAND THAT**
   - The Mehra Clinic, PLLC does not bill insurance and is out of network for all insurance at this time.
3. I must pay for the cost of these services.
4. I understand that :
   - I have the right to refuse treatment or medication Management
   - I have the right to discuss all health treatment with the provider

_____ _____.
Patient's Signature Date

_____ _____
Parent or Guardian Signature Date
(For children under 18 years)

_____ _____
Print Name Date