SATORI
HEALING

Consent to Treat Form

1. I_____(patient name)_____(DOB) give Permission for the medical providers at ***Satori Healing, LLC,*** to give me medical treatment.

2. I allow the medical provider at ***Satori Healing, LLC,*** to file for insurance benefits to pay for the care I receive.

3. If I am choosing to utilize my health insurance (FFS) and not participate in Direct Primary Care (DPC) membership:
- ***Satori Healing, LLC*** will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

4. I understand that **if I choose** to participate in the DPC membership:
- Satori Healing WILL NOT submit any claims to my insurance.
- I will not submit any claims to insurance for reimbursement

5. I understand that:
- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my clinician.

Patient/Guardian Signature: _____

Print Patient/Guardian's Name: _____

Date:_____

This consent form remains valid until one year from the date of signature, unless effectively revoked in writing by the individual before that date.