Raphael Medicine & Therapies PC
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CONSENT FOR TREATMENT

I am aware that the medical work as practiced by M. Kelly Sutton, M.D. may extend beyond conventional medical treatment. I have had an opportunity to ask questions regarding her practice approach. It is with this information that I request the services as provided and prescribed by M. Kelly Sutton, M.D.

I also acknowledge and agree to pay no more than 50% ($15-$120.00 based on visit length) of the visit fee for no-show appointments and for cancellations made less than on full business day in advance. I agree to pay $35.00 fee for returned checks.

If parent or guardian of a minor, I have read and understood the California Minor Consent Laws.

If the minor has dual custody, I have provided RMTPC with the decree covering medical decision-making, and contact information for all responsible parties.

If I am a caretaker or guardian for the patient, I have provided RMTPC with legal documents relevant to medical decision-making, and contact information for all responsible parties.

Printed name of Patient: _____

Signature of responsible party: _____
Date: _____

Printed Name of responsible party: _____