

PHYSICIAN NAME: _____
CLINIC: _____
ADDRESS: _____
PHONE NO.: _____

Signature(s)

Date

CONSENT FOR TREATMENT OF CHILDREN AND ADOLESCENTS:

I/We consent that _____ may be treated as a client or clients by Reem Cutinello.
At times it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the
timeliest treatment for you and your children.

Signature(s)

Date