HALO
A MODERN WELLNESS LAB

I _____ (patient name) give permission for **HALO Modern Wellness Lab ("HALO")** to provide treatment.

I allow **HALO** to file for insurance benefits to pay for the care I receive, if applicable.
I understand that:

- **HALO** 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.

I understand:

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

_____ _____

Patient's Signature Date

_____ _____

Parent or Guardian Signature Date

(for children under 18)

_____

Print Parent or Guardian Name, *if applicable*