

Raphael Medicine & Therapies
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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% of the visit fee for no-show appointments and for cancellations made less than 24 hours in advance. I agree to pay \$35.00 fee for returned checks.

Signature _____ Date _____

Printed Name _____