Family First Health
Initial Visit Disclaimer Form

Account #____________________

Patient Name __________________________________ **Date of Birth** _________________

Email Address_________________________________

I, ____ authorize Family First Health
(Patient, Parent or Guardian)

through their employees to render health services to the above named patient, and I guarantee payment for these health services.

X:____ ______________________
Signature of patient, parent, guardian or guarantor Date

X:____ ______________________
Witness