

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
