Treatment Agreement

Date:__________

Patient:____

Address:____

City/Town:____

State/Zip:____

Telephone:____

I, ____ (DOB:___ __ ___), wish to have Doctor _____________________ and Michael Witort, P.L.R.N. take care of my health care needs.

Doctor _________________ is a ______________________, and Michael Witort is a a Naturopath and alternative healthcare practitioner who practices Reflexology to relieve pain.

____ ______________

Patient **Date Signed**

Acknowledged by:

____ ______________

Doctor **Date Signed**

____ ______________

Michael Witort, P.L.R.N. **Date Signed**

____ Appropriate and Inappropriate touch policy explained to patient.

Mike "Doc" Witort, P.L.R.N.
Privately Licensed Research Naturopath