MARC J. KORNFIELD, M.D., P.C.
PHYSICAL MEDICINE & REHABILITATION

CONSENT TO TREAT

I, ____, give Marc J. Kornfield, MD, PC,
(PRINT NAME)
consent to treat my medical condition that requires me to receive pain management care such as medication management, physical therapy, rehabilitation counseling and biofeedback.

Patient Name: ____ **Date of Birth:** ____________
(PRINT NAME)

Signature of Patient/Guardian: ____

Relationship (if Guardian): ______________________________ **Date:** __________________

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