Manely Ghaffari, MD
129 N. 4th Street, Office 1F
Philadelphia, PA 19106

Consent To Treatment

Patient's Name: ___________________________________ DOB:_______________

I consent to evaluation and/or treatment of myself and/or my child by Dr. Ghaffari. Dr. Ghaffari has explained to me the advantages and disadvantages of treatment that may include medication management.

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Patient's Signature **Date** **_____________________**

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Parent/Guardian if Patient is Under Age 14 **Date** **_____________________**

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Dr. Manely Ghaffari Signature **Date** **_____________________**