Town Center Pediatrics
Required Signatures

CONSENT TO TREAT

I am the parent/guardian of _____. I have the legal right and responsibility to obtain and consent to medical and surgical treatment for this patient.
I voluntarily authorize and consent to such medical care, treatment, and diagnostic tests that Dr. _____ or her designated associates believe are necessary for this child. I understand that by signing this form, and by bringing this child to this medical office for care, I am giving permission to the doctors and other health care providers in this office to provide treatment to this patient as long as he/she is a patient of this practice.

DELAGATION OF CONSENT

I hereby authorize (when I am unavailable to give consent) the following individual(s) _____ _____, whose relationship to this patient is _____, to consent to any and all medical care and attention for this child which is deemed necessary and appropriate by a healthcare provider licensed in the State of Texas. This consent includes medical and surgical intervention, and elective as well as emergency care. This delegation shall be valid until I withdraw this delegation of consent.

_____ _____ _____
*Signature of Parent/Guardian Relationship to patient Date

_____ *To be signed and witnessed at the office.
Witness

WRITTEN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, you acknowledge receiving the Town Center Pediatrics Notice of Privacy Practices ("Notice"). The Notice explains how Town Center Pediatrics may use and disclose your child's protected health information for treatment, payment, and health care operations purposes. "Protected health information" means your child's personal health information found in his/her medical and/or billing records.
Your signature below only acknowledges that you have RECEIVED the Notice. If you have questions about the Notice, please contact the Privacy Officer for the office.

_____ _____
Patient's Name Patient's Representative

_____ _____ _____
Relationship of Representative to Patient Representatives Signature Date

GUARANTOR'S STATEMENT OF RESPONSIBILITY

I have received a copy of the Practice's Financial Policy and understand that I am personally responsible for the payment of this patient's account.

_____ Date: _____
Guarantor's Signature

_____ Relationship to Patient: _____
Print Name of Responsible Party