



Need a baby Doctor?

4461 Coit Road
Suite 315
Frisco, TX 75035

CONSENT TO TREAT

I give my consent for diagnosis and treatment to Collin County Pediatrics to provide medical care reasonable by today's standards to my minor child. This includes, but is not limited to: physical examination, evaluation of illness and injuries, routine immunizations, lab testing and minor procedures. Verbal consent will be obtained prior to each immunization. Vaccine information sheets are available in each exam room. Your child's digital photograph may be taken and incorporated into the electronic medical record.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have had the opportunity to review a copy of the Notice of Privacy Practices which explains how your medical information will be used and disclosed. This is posted in the office and a copy is available upon request.

ASSIGNMENT OF BENEFITS

I hereby assign Collin County Pediatrics all right, title, and interest to any benefit payable for medical coverage. I direct that such benefits be paid directly to Collin County Pediatrics and I will be responsible for any charges accrued and not paid by the insurance company. I am responsible for all co-pays, deductibles, co-insurance and non-covered services.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the release of my child's medical information by Collin County Pediatrics to any consulting physician, hospital, and third-party payers such as insurance companies, government agencies, self insurance employer or utilization review organization.

LIMITATIONS (if any)

I have identified these specific limitations for this authorization:

This document remains in effect unless revoked in writing.

Child's Name

X _____
Signature of Parent/Guardian

Date