PRESTON HOLLOW
PEDIATRICS

Consent to Treat

I hereby authorize the physicians of Preston Hollow Pediatrics to provide medical care reasonable by today's standards.

Patient Printed Name: _____ Date of Birth: _____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____Today's Date: _____

_____ **Initial here:** to grant consent for Preston Hollow Pediatrics to leave voicemails with lab results, prescription details and medical questions.

Assignment of Benefits

I hereby assign to Preston Hollow Pediatrics any insurance or other third-party benefits available for health care services provided. I understand that Preston Hollow Pediatrics has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Preston Hollow Pediatrics, I agree to forward all health insurance and other third-party payments received for services rendered to Preston Hollow Pediatrics immediately upon receipt.

Patient Printed Name: _____ Date of Birth: _____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____Today's Date: _____

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