450 N Standridge Blvd STE 101
Anna TX, 75409
Phone: 972-464-2300
Fax: 972-468-1777

230 E. Sycamore St. STE 100
Sherman, TX 75090
Phone: 903-202-2900
Fax: 903-202-2901

Pediatric and Adolescent Medicine

_____ _____ _____
Patient Name – PRINT Date of Birth Social Security Number (Optional)

CONSENT FOR TREATMENT

The patient and/or parent/guardian/legal representative agree and consent to general medical treatment by all Texoma Physicians Group, PLLC physicians and providers and furthermore consent to the full access, review and use of the patient's medical records by all Texoma Physicians Group, PLLC. The patient and/or parent/guardian/legal representative also agrees and consents for Texoma Physicians Group, PLLC to view the patient's Rx History from an external source.

UNDERSTANDING OF FINANCIAL RESPONSIBILITY

All professional services rendered will be charged to the patient and/or guarantor. Necessary forms will be completed to expedite insurance carrier payments. However, it is understood and agreed that the patient is responsible for all fees regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance.

INSURANCE AUTHORIZATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Texoma Physicians Group, PLLC to furnish information concerning my medical condition and treatment thereof to insurance carriers. I also assign insurance benefits paid on my behalf by any and all insurance companies that cover the expenses I incur as the result of any diagnostic services or treatment provided to me by any Texoma Physicians Group, PLLC physician or provider. I further understand and agree that this agreement remains in force until revoked by me in writing.

HIPAA – NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about the patient may be used and disclosed and how I can get access to this information. Per my signature below, I acknowledge that Texoma Physicians Group, PLLC Note of Privacy Practices has been provided to me if requested.

Please call our office if you are going to be late or miss an appointment. No show fee is $25.00. If your family has three no shows within a 12 – month period, you will be dismissed from TPG.

_____ _____ _____
PRINT – Patient/Parent/Guardian/Legal Representative Relationship to Patient Date

_____
SIGNATURE – Patient/Parent/Guardian/Legal Representative