

Pediatric Specialists of Plano, Inc.

Consent for Office Procedures

I, _____ authorize and direct _____
(parent or guardian) (name of physician)

to perform upon _____
(name of patient)

examination and necessary treatment provided by Pediatric Specialists of Plano.

I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of the procedures and/or treatments.

Parent or
guardian signature _____ Date _____

Relationship to patient _____

Witness _____ Date _____