PSOP KIDS
PEDIATRIC SPECIALISTS OF PLANO

General Consent

Consent to Treat

I consent to and authorize the physicians, nurses, and other healthcare providers at Pediatric Specialists of Plano to perform appropriate healthcare examinations, treatment, diagnostic testing or medication administration as deemed medically necessary by their professional judgement. I know that there are some risks with all medical treatments and procedures and I understand that no one can guarantee how well treatments or procedures will work.

Assignment of Benefits/Payments for Services

I authorize payment of any and all benefits to Pediatric Specialists of Plano. I know that I must pay for any charges for my care that are not covered by my insurance, health plan, or government programs. I realize I must cooperate with Pediatric Specialists of Plano to get payment for my care. If I am eligiblefor payment from more than one type of coverage, Pediatric Specialists of Plano will return any extra payments to the payor. If I have an unpaid bill at Pediatric Specialists of Plano, any refunds due to me will be put on my unpaid bill. If there is money leftover after my bill is paid, I will get a refund from Pediatric Specialists of Plano.

Other Individuals Authorized to Consent to Treatment

In addition to the legal guardians of the patient, the following persons are authorized to consent to any recommended medical care for my child: (e.g. grandparents, nanny, siblings over the age of 18 years, etc):

Name:	**Relationship to child:**
1. _____	_____
2. _____	_____
3. _____	_____

My signature here means I have read this information and understand it. This consent is valid until revoked in writing.

Patient Name: _____ **Date of Birth:** _____

Signature: _____ **Date:** _____

Print Name: _____ **Relationship to Patient:** _____