Trophy Club Pediatrics
Providing excellent medical care for your child

Consent for Medical Treatment

I do hereby voluntarily consent to and authorize Trophy Club Pediatrics (TCP) to provide care which encompasses all diagnostic and therapeutic treatments, including HIV testing, considered necessary or advisable in the judgment of the attending physician or her/his designee. By signing this form, I do not waive my right to refuse recommended tests or treatments

Acknowledgement of Use and Disclosure of Protected Health Information

I Understand:

- Trophy Club Pediatrics personnel and my physician will create and maintain a record of the care and services provided to me.
- Information relating to my treatment, payment or health care operations may be used or disclosed in the delivery and management of care and services provided by Trophy Club Pediatrics.
- I have received a copy of Trophy Club Pediatrics' Notice of Privacy which describes how my protected health information may be used or disclosed.
- I have received, read and understand the Patient Bill of Rights

Preservation of Records: Trophy Club Pediatrics may authorize disposal of medical records relating to the patient on or after the time periods specified in the Texas Health and Safety code.

Valuables: I understand that Trophy Club Pediatrics does not assume responsibility for the safekeeping of any personal property that I choose to keep on my person or in the clinic during my visit.

Financial Responsibility and Assignment of Benefits. In consideration for receiving medical or health care services, I hereby assign to TCP physicians and providers my right, title, and interest in all insurance, Medicare/Medicaid, or other third-party payer benefits for medical or health care services otherwise payable to me. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third-party payer, up to the total amount of my medical and health care charges, to TCP physicians I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid, is correct. I agree to pay all charges for medical and health care services not covered by, or which exceed, the amount estimated to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third-party payer, and agree to make payment as requested by TCP

Length of Time Consent is in Effect: The Consent to Treatment will be valid and remain in effect as long as the patient seeks health care in the TCP clinics, unless revoked by the patient in writing with written notice provided to clinic attended by the patient. Occasionally the form may be revised and will require a new signature

I have read and understand this form. The information has been explained to me to my satisfaction, I accept and agree to the items contained in this Consent to Medical Treatment.

Patient's Signature	
Authorized Representative's Signature	
Authorized Representative's Name	
Relationship of Authorized Representative	
Date and Time	
TCP Representative Signature	
TCP Representative Name	
Date and Time	