CONSENT TO TREAT

Notice of Privacy Practices Acknowledgement

_____
(Please initial) I acknowledge that Houston Area Pediatric Neurology, PLLC provided me with a written copy of his/her Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

General Consent to Treat

_____
(Please initial) I am the parent/guardian of _____ (name of patient). I have the legal right to consent to medical and surgical treatment for this patient.

I voluntarily authorize and consent to the medical care, treatment and diagnostic tests that Dr. Melissa Jones and her designated associates or assistants believe are necessary for this child. I understand that by signing this form, I am giving permission to the doctors, nurses, physician assistants and other healthcare providers in this medical office to provide treatment to this child as long as this child is a patient in this office, or until I withdraw my consent.

Consent to Release and Obtain Information

_____
(Please initial) In agreement with federal and state law, I agree to allow Houston Area Pediatric Neurology, PLLC to deliver the necessary care to this child in order to provide continuity of care and treatment. Houston Area Pediatric neurology, PLLC and/or the patient's provider may obtain from any source and examine use, or discuss and disclose, the patient's medical record and information to treating hospital personnel and agents, other healthcare providers, medical records auditors, professional committees, care evaluators and governmental agencies. This information can include, but is not limited to: medical history, examinations, diagnoses, treatments any psychiatric, drug and alcohol abuse or genetic testing information, or HIV or AIDS information. This consent to release and obtain information is valid until revoked. The undersigned may revoke the consent in writing at any time, except with regard to disclosures that have already been made in reliance on such consent.

_____
(Please initial) I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.

Electronic Prescriptions (E-Prescribing)

_____
(Please initial) I voluntarily authorize Houston Area Pediatric Neurology, PLLC to allow E-Prescribing for the patients mail order prescription, which allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medical dispense history as long as this child is a patient at this office, or until I withdraw my consent.

Pharmacy Information:

Name of Pharmacy:_____ Phone:_____

Address: _____

Name of Patient _____

Patient's Date of Birth _____

Printed Name of Patient's Representative_____

Relationship of Patient's Representative_____

Signature of Patient or Patient's Representative_____

Date_____