



PEDIATRIC CENTER OFFICE ENCOUNTER RECORD

1. AUTHORIZATION FOR TREATMENT

I, (or We) hereby grant permission to, authorize and direct the authorities of Pediatric Center to perform such medical and/or surgical procedures on me (him or her) as they deem in their judgement advisable or necessary for the treatment or care of (1) any conditions now recognized or contemplated, and (2) any conditions, not now recognized or contemplated, which are revealed or arise during the course of such treatment or care.

I, (or We) acknowledge that no warranty or guarantee has been made as to the results that may be obtained from such treatment and care, that I (or we) understand the nature and purpose of the above authorized treatment, and that I (or we) have fully informed myself (or ourselves) of the contents and effects of the above Consent and Authorization, and do hereby freely give my (or our) consent thereto.

SIGNED _____

DATE

NEAREST RELATIVE, LEGAL GUARDIAN OR OTHER
PERSON AUTHORIZED TO CONSENT FOR PATIENT.

RELATIONSHIP TO PATIENT

WITNESS _____

2. ASSIGNMENT OF BENEFITS TO PEDIATRIC CENTER

ASSIGNMENT OF BENEFITS

I certify that the information given by me is true and correct to the best of my knowledge and promise to pay Pediatric Center, 1300 Main Street, Richmond, Texas 77469, all charges for the patient in accordance with the regular tariffs of the Hospital and/or Pediatric Center that are not covered or payable by this assignment. I hereby authorize payment to Pediatric Center the benefits payable to me. In applying for payment under Title XVII of the Social Security Act, I request payment of authorized benefits be made on my behalf to those who accept this assignment. I hereby authorize the use of a photographic reproduction or facsimile of this authorization in place of the original.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any holder of medical information about me to release to my insurance carrier of sponsoring agency or the Social Security Administration or its intermediaries or carriers, when relevant, information requested by them and needed for processing of benefit claim.

SIGNED _____

DATE

NEAREST RELATIVE, LEGAL GUARDIAN OR OTHER
PERSON AUTHORIZED TO CONSENT FOR PATIENT.

NURSE/CLERK _____