EL PASO CHILD NEUROLOGY

CONSENT FOR TREATMENT

I voluntarily consent to receive medical and health care services for myself/child provided by the doctor(s) in El Paso Child Neurology employees and such associates, assistants, and other health care providers as my physicians deem necessary. I understand that such services may include diagnostic procedures, examination, and treatment. I acknowledge that no warranty or guarantee has been made to me as to result or cure. I understand that this consent for treatment will be valid and remain in effect as long as I attend any clinics from the doctor(s) of El Paso Child Neurology unless revoked by me in writing with such written notice provided to each clinic attended by me/ my child.

NOTICE OF OFFICE POLICIES

I have read and understand company policies. A copy has been provided as a reference

NOTICE OF PRIVACY PRACTICES

I have read and understand Privacy Practices policies

HIPAA CONSENT AGREEMENT

I have read and understand the HIPAA consent form agreement

DELIVERY PREFERENCES OF MEDICAL RECORDS

I have read and understand the Delivery of Medical Records policy

_____	_____
Print Name	Date
_____	_____
Parent/Legal Guardian Signature	Date
_____	_____
(Staff Member)	Date