



4201 Bee Cave Road, Suite C-100
Austin, TX 78746
512.327.1155 512.327.1156 fax

Consent to Treat

I (or my legal guardian or parent) hereby authorize the physicians of Schoolhouse Pediatrics to provide medical care reasonable by today's standards.

Patient Name (please print): _____

Date of Birth: _____

Signature of Patient / Legal Guardian: _____

Date: _____

Assignment of Benefits

I hereby assign to Schoolhouse Pediatrics any insurance or other third-party benefits available for health care services provided to me. I understand that Schoolhouse Pediatrics has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Schoolhouse Pediatrics, I agree to forward Schoolhouse Pediatrics all health insurance and other third-party payments that I receive for such services rendered to me immediately upon receipt.

Signature of Patient / Legal Guardian: _____

Date: _____