PEDIATRIC NEUROLOGY OF DALLAS
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Acknowledgement of Receipt for Notice of Privacy Practices and General Consent for Medical Treatment

I hereby give my consent to the Physicians of Pediatric Neurology Dallas to use the medical information of my child for the purposes of treatment, payment, or health care operations. I understand that should my child's physician be absent, this consent is transferable to the physician covering the practice. Assignment of Benefits: I request that payments of medical benefits be made to Pediatric Neurology of Dallas. I authorize release of medical information necessary to provide treatment, payment of claim, or health care operations: A photo static copy is as valid as the original.

My signature below verifies I have received a copy of the "Notice of Privacy Practices" for Pediatric Neurology of Dallas (7777 Forest Lane, Suite A-317, Dallas, Texas 75230) and that I have been provided with a copy of the office policy. I understand fees are payable at the time services are rendered and I understand the Physicians of Pediatric Neurology of Dallas do not accept Medicaid or Medicare.

______________________________________ ______________________________________
Parent Name (please print) Patient Name (please print)

______________________________________ ______________________________________
Parent Signature (Please print) Date

For Office Use Only

We attempted to obtain written acknowledge and receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_______ Individual refused to sign

_______ Communications barriers prohibited obtaining acknowledgement

_______ Emergency situation prevented us from obtaining acknowledgement

_______ Other - Please specify: ____________________________________
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Initial and Date: ______________________________________