

**NIGHTLIGHT PEDIATRIC URGENT
CONSENT AND SIGNATURE**

PATIENT NAME: _____

CONSENT TO TREAT

I have the legal right and responsibility to obtain and consent to medical and surgical treatment for this patient. I voluntarily authorize and consent to such medical care, treatment, and diagnostic tests that Nightlight Pediatric Urgent Care Providers believe are necessary for this child. I understand that by signing this form, and by bringing this child to this medical office for care, I am giving permission to the doctors and other health care provid in this office to provide treatment to this patient as long as he/she is a patient of this practice.

DELEGATION OF CONSENT

(This section is OPTIONAL. Include adults other than parents/legal guardians)

I hereby authorize (when I am unavailable to give consent) to the following individual(s):

_____ Name of Person	_____ Relationship to Patient
_____ Name of Person	_____ Relationship to Patient
_____ Name of Person	_____ Relationship to Patient

to consent to any and all medical care and attention for this child which is deemed necessary and appropriate by a healthcare provider licensed in the State of Texas. This consent includes medical and surgical intervention, and elective as well as emergency care. This delegation shall be valid until I withdraw this delegation of consent.

**WRITTEN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY
PRACTICES**

By signing below, you acknowledge receiving the Nightlight Pediatric Urgent Care Notice of Privacy Practices ("Notice"). The Notice explains how Nightlight Pediatrics may use and disclose your child's protected health information for treatment, payment, and health care operations purposes. "Protected health information" means y child's personal health information found in his/her medical and/or billing records. Your signature below only acknowledges that you have RECEIVED the Notice. If you have questions about the Notice, please contact the Privacy Officer for the office.

GUARANTOR'S STATEMENT OF RESPONSIBILITY

I have received a copy of the Nightlight Pediatric Urgent Care's Financial Policy and understand that I am persona responsible for the payment of this patient's account.

SIGNATURE ACKNOWLEDGES I RECEIVED AND UNDERSTAND THE STATEMENTS ABOVE.

_____ Guarantor's Signature	_____ Date
_____ Guarantor's PRINTED Name	_____ Relationship to Patient