

# NORTH TEXAS INFECTIOUS DISEASES CONSULTANTS, PA

## Consent for Treatment

I, AS A PATIENT/LEGAL GUARDIAN, DO CONSENT FOR MEDICAL TREATMENT BY NORTH TEXAS INFECTIOUS DISEASES CONSULTANTS' (NTIDC) PHYSICIANS AND PHYSICIAN ASSISTANTS, THIS IS INCLUSIVE OF ANY TREATMENT OR PROCEDURE THEY DEEM MEDICALLY NECESSARY.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

## Authorization to Release Medical Information

THIS IS TO SERVE AS AUTHORIZATION TO RELEASE MEDICAL INFORMATION COMPILED IN THE COURSE OF MEDICAL TREATMENT AT NTIDC TO THE UNDERSIGNED PATIENT. A COPY OF THIS WILL SERVE AS AN ORIGINAL.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

## Acknowledgement of Reading Notice of Privacy Information Practices

I ACKNOWLEDGE AND AGREE THAT I HAVE READ NTIDC NOTICE OF PRIVACY PRACTICES. I ALSO UNDERSTAND THAT I WILL BE GIVEN A COPY OF THE NOTICE IF I ASK FOR ONE.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

## Late Fee Policy

If you are more than **15 minutes** late for a scheduled appointment, it may be necessary for you to re-schedule your appointment. If you know you are running late, call our office and we will tell you if we can work you in without inconveniencing the patients who are on time. Failure to show up for your appointment, without giving our office **at least 24** hour notice, will **cause you to incur a \$30 no-show fee**. Other fees may also be incurred if any specially mixed medications designated for your treatment have been purchased and mixed on your behalf.

NTIDC personnel will make every effort to remind you prior to your appointment, to include leaving a message at the phone number furnished to this office by you.

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date