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.

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.

Acknowledgement of Receiving and Reading a Copy of,
"Notice of Privacy Practices" and "Patient Rights and Responsibilities"

I acknowledge receipt of NTIDC's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how NTIDC may use and disclose by confidential information. I understand that NTIDC reserves the right to change their privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be made available to me upon request.

Tardy and Late Cancellation Policy

In order to best serve all of our patients it may be necessary to reschedule your appointment if you are 15 minutes late or more. Failure to come in for your appointment without giving our office at least 24 hours notice may result in a $30 charge on your account.

Physician Assistant Consent for Treatment

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care. "Supervision" does not require the constant physical presence of a supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.
I understand that at any time I can refuse to see the physician assistant and request to see a physician.

I have read the information above and consent to all.

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Print Patient Name   **Date of Birth**   **Patient's Signature**   **Date**