Pediatric Center of Round Rock, P.A. dba River Ridge Pediatrics

1526 Leander Road
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Phone 512-863-7586 Fax 512-863-5222

# CONSENT TO TREAT

Patient Name: _____DOB: _____

## CONSENT FOR TREATMENT

I hereby authorize evaluation and treatment by the providers and staff associated with River Ridge Pediatrics. I understand and agree that the signatures and dates on this form will not expire without written notice or in the case that a minor becomes the age of 18, and that a photocopy of this form is considered valid as original.

**Printed Name of Parent or Guardian**_____

**Signature of Parent or Guardian**_____**Date**_____

**Printed Name of Parent or Guardian**_____

**Signature of Parent or Guardian**_____**Date**_____