PGV PEDIATRICS, P.A.

3417 GASTON AVENUE, SUITE 845,

DALLAS, TX 75246

PHONE: (214)823-2552

FAX: (214)823-2551

Acknowledgement of Receipt of Notice of Privacy Practices and General Consent for Medical Treatment

I hereby give my consent to the physicians of PGV Pediatrics, P.A. 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 PGV Pediatrics, P.A. directly. I authorize release of medical information necessary to provide treatment, payment of claim, or other health care operations. A photo static copy is as valid as the original.

My signature below verifies I have been provided a copy of the "Notice of Privacy Practices" for PGV Pediatrics, P.A. (3417 Gaston Avenue, Suite 845, Dallas, TX 75246) and that I have also been provided with a copy of the office policy. I understand fees are payable at the time services are rendered.

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Parent Name (please print)	Patient Name (please print)
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Parent Signature	Date