



Pediatric Center of Round Rock, P.A. dba River Ridge Pediatrics
1526 Leander Road
Georgetown, Texas 78628
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 _____