LUV-N-CARE PEDIATRICS

Authorization for Medical Treatment

I,_____, a patient at Luv-N-Care Pediatrics, hereby authorize **Dr. Ambreen Aslam**, as my Physician, and such associates, **Medical /Technical Assistants**, and other health care providers as deemed necessary on the basis of findings during the course of the visit. I certify that I have read the above authorization and understand the same, and also certify that no guarantee or assurance has been made as the results that may be obtained.

Financial Responsibility

I/We hereby assume financial responsibility for the payment of all charges for services rendered to the above patient. I/We hereby assign and authorize payment directly to Ambreen Aslam, M.D., (Luv-N-Care Pediatrics) of all clinic benefits an guarantee to pay any balance at the time or request. I/We understand that all insurance benefits are assigned to the clinic until the claim is totally paid. I/We understand that insurance does not relieve obligations for this account. By this signature, I acknowledge and agree to the conditions stipulated in “Authorization to Release Medical Records Information”.

_____

Name of Patient

_____ _____

Signature of Patient /Parent (if minor) Date

_____ _____

Witness Date

11811 Fallbrook Dr., Suite B-2, Houston, Texas 77065 ♥ PH: 832-237-8882 - FX: 832-237-8886
www.luv-n-carepediatrics.com