

**AMARILLO FAMILY PHYSICIANS CLINIC, P.A.**  
1215 S. COULTER, SUITE 100  
AMARILLO, TEXAS 79106  
(806) 359-4701

**CONSENT TO TREATMENT**

1. I hereby voluntarily consent to outpatient care at the office of Amarillo Family Physicians Clinic, P.A. encompassing routine diagnostic procedures, examinations and medical treatment including (but not limited to) routine laboratory work (such as blood, urine, and other studies), taking of X-rays, heart tracings and administration of medications prescribed by the physicians.
2. I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by Amarillo Family Physicians Clinic, P.A., and its physicians and physician assistants as is necessary in the medical staff's judgment.
3. I understand that this consent form will be valid and remain in effect as long as I (he/she) attends Amarillo Family Physicians Clinic.
4. I hereby authorize my insurance carrier(s) to pay directly to Amarillo Family Physicians Clinic all benefits due me, if any, by reason of service described in the statements rendered and as provided for in the policy contract with my insurance carrier(s).
5. This form has been explained to me and I understand its contents.

\_\_\_\_\_  
Signature of Patient or  
Person Authorized to Consent for Patient

\_\_\_\_\_  
Date

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If patient is a minor or is unable to consent, \_\_\_\_\_

Patient Name

A. Patient is a Minor \_\_\_\_\_ years of age.

Name of Father \_\_\_\_\_ Name of Mother \_\_\_\_\_

B. Patient is unable to consent because \_\_\_\_\_

\_\_\_\_\_  
Signature of Person Authorized to Consent for Patient

\_\_\_\_\_  
Relationship

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**CONSENT TO TREATMENT**