Consent for Treatment
Baylor College of Medicine

I voluntarily give my permission to the health care providers of Baylor College of Medicine or BaylorMedCare and such assistants and other health care providers as they may deem necessary to provide medical services to me. I understand by signing this form, I am authorizing them to treat me for as long as I seek care from Baylor College of Medicine or BaylorMedCare providers, or until I withdraw my consent in writing.

Signature of Patient or Guardian Date

Printed Name of Patient or Guardian Relationship to Patient

Statement of Financial Responsibility/Assignment of Benefits
Baylor College of Medicine

I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by representatives of Baylor College of Medicine or BaylorMedCare. I assign and authorize payments to Baylor College of Medicine or BaylorMedCare. I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law.

Signature of Patient or Guardian Date

Printed Name of Patient or Guardian Relationship to Patient

A duplicate or faxed copy of this form is considered the same as the original document.