AMINA JABEEN AHMED, M.D., P.A.
18400 Katy Freeway, Suite 440
Houston, TX 77094

CONSENT FOR TREATMENT

I, ________________________________, the patient/legal guardian of ______________________, authorize and direct **Dr. Ahmed** to perform necessary diagnostic test and evaluations, as deemed medically indicated on myself. I understand that any testing to be done and/or treatment to be given will be explained to me prior to the performance of the exam, and that I may ask questions about such testing.

LABORATORY TESTING

Laboratory testing which my physician may order, may not be covered by my insurance plan. I accept financial responsibility for any laboratory charges which may not be covered.

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

PATIENT MESSAGES AUTHORIZATION FOR CALL BACK

Home Phone #: ______________________________________

Work Phone #: ______________________________________

Cell Phone #: ______________________________________

Whom may we give medical information to?

A. Spouse ____

B. Children ____

C. Other: Name and Relationship _____________________________________

May we leave results/messages on your recorder/voicemail?

At home Yes _______ No _________

At work Yes _______ No _________

Signature ____ Date ________________