

**Dixon Golden, O.D.**  
**P.O. Box 1838**  
**Center, Texas 75935**  
**(936) 598-8501    (800) 243-1981**

**GENERAL CONSENT**

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_

You may leave any of the following information blank if you object to giving us the information. Should you want to change, add, or omit this information at anytime, please contact us.

1. Please print the names of family members of other persons whom you wish us to inform about your medical condition and diagnosis. \_\_\_\_\_  
\_\_\_\_\_
2. If you wish to use a different address than your home address for receiving statements and other correspondence, please print \_\_\_\_\_
3. For an emergency only, please print the names of the family members or persons whom we may inform about your medical condition. \_\_\_\_\_  
\_\_\_\_\_
4. Please print a phone number, if other than your home phone, where you want to receive calls regarding appointments, diagnoses, or other health information. (    ) \_\_\_\_\_
5. Can we leave confidential messages on your home phone answering machine or voicemail? Or, if you gave us another phone number to call, can we don the same on that phone number?  
\_\_\_\_ Yes \_\_\_\_ No
6. If you do not have an answering machine or voicemail, can a confidential message be left at your place of employment? \_\_\_\_ Yes \_\_\_\_ No

**Privacy Practice Notice:** I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

**RELEASE & AUTHORIZATION:** I hereby authorize release of any information concerning my (or my child's) examination and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also authorize payment directly to the doctor for any insurance benefits otherwise payable to me. I realize this may not represent full payment and understand I will be responsible for the balance due after any insurance is collected.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Today's Date