I have been informed by ENT CONSULTANTS OF NORTH TEXAS, of the risks, possible alternative methods of treatment, and possible consequences involved in the treatment by means of: under the general anesthesia for the relief of: Understanding this, I hereby authorize the above named doctor to administer such treatment to me. Patient or person authorized to consent for patient. Witness SURGERY AND PRE-OP/POST-OP APPOINTMENT SCHEDULE PATIENT'S NAME: ACCT# HOSPITAL: Baylor Medical Center Garland TIME: DOCTOR'S PRE-OP DATE: DOCTOR'S PRE-OP LOCATION: HOSPITAL PRE-OP DATE: TIME: SURGERY DATE: TIME: DOCTOR'S POST-OP DATE: DOCTOR'S POST-OP LOCATION: 7150 N. Pres. George Bush Hwy #202 Garland Office \*THE HOSPITAL ADMITTING OFFICE WILL INFORM YOU OF THE EXACT TIME OF SURGERY. **AUTHORIZATION TO PAY PROVIDER** I hereby authorize payment be sent directly to the provider of medical services rendered, otherwise payment to me as determined by the insurance company. I understand I am financially responsible to the provider of services for charges not covered by this authorization. I assign benefits to ENT Consultants of North Texas and agree to act as trustee of funds in the event that they are paid

to me.

X Signature\_\_\_\_\_\_ Date

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize ENT Consultants of North Texas to release any information requested by the insurance company or its representative.

X Signature\_\_\_\_ Date

I have been informed by ENT CONSULTANTS OF NORTH TEXAS, of the risks, possible alternative methods of treatment, and possible consequences involved in the treatment by means of:		
under the general anesthesia for the relief of:		
Understanding this, I hereby authorize the ab	pove named doctor to administer such treatment to me.	
Witness	Patient or person authorized to consent for patient.	
SURGERY AND PRE-	OP/POST-OP APPOINTMENT SCHEDULE	
PATIENT'S NAME:	ACCT#	
HOSPITAL: Baylor Surgicare		
DOCTOR'S PRE-OP DATE:	TIME:	
DOCTOR'S PRE-OP LOCATION: (Anesth	nesiologist will call you night before surgery with time.)	
HOSPITAL PRE-OP DATE:	TIME:	
SURGERY DATE:	TIME:	
DOCTOR'S POST-OP DATE:	TIME:	
DOCTOR'S POST-OP LOCATION: 3600	Gaston Avenue Barnett Tower #911 Dallas office	
*THE ANESTHESIOLOGIST WILL IN	FORM YOU OF THE EXACT TIME OF SURGERY.	
I hereby authorize payment be sent directly to the pro the insurance company. I understand I am financially	<b>IZATION TO PAY PROVIDER</b> vider of medical services rendered, otherwise payment to me as determined by responsible to the provider of services for charges not covered by this f North Texas and agree to act as trustee of funds in the event that they are paid	
X Signature	Date	
AUTHORIZATION TO RELEASE INFORMATION requested by the insurance company or its representat	V: I hereby authorize ENT Consultants of North Texas to release any information ive.	
X Signature	Date	

I have been informed by ENT CONSULTANTS OF NORTH TEXAS, of the risks, possible alternative methods of treatment, and possible consequences involved in the treatment by means of:		
under the general anesthesia for the relief of:		
Understanding this, I hereby authorize the above nar	med doctor to administer such treatment to me.	
Witness	Patient or person authorized to consent for patient.	
SURGERY AND PRE-OP/POS	ST-OP APPOINTMENT SCHEDULE	
PATIENT'S NAME:	ACCT#	
HOSPITAL: Baylor University Medical Center L	Dallas Dallas	
DOCTOR'S PRE-OP DATE:	TIME:	
<i>[GO TO WADLEY 7]</i> DOCTOR'S PRE-OP LOCATION: (Nurse will call	TOWER #254 FOR PRE-OP LAB & REGISTRATION] I you night before surgery with time.)	
[Call 214-820-6200 p HOSPITAL PRE-OP DATE: Thursday/Friday,	pre-admit dept. to schedule appointment date & time) TIME: between 8:00am & 5:00pm	
SURGERY DATE:	TIME:	
DOCTOR'S POST-OP DATE:	TIME:	
DOCTOR'S POST-OP LOCATION: 3600 Gaston *NURSE WILL INFORM YOU OF		
AUTHORIZATIO	ON TO PAY PROVIDER	
the insurance company. I understand I am financially responsi	medical services rendered, otherwise payment to me as determined by able to the provider of services for charges not covered by this Texas and agree to act as trustee of funds in the event that they are paid	
X Signature	Date	
AUTHORIZATION TO RELEASE INFORMATION: I herebrequested by the insurance company or its representative.	by authorize ENT Consultants of North Texas to release any information	
X Signature		
ENT CONSULTA	ANTS OF NORTH TEXAS	

I have been informed by ENT CONSULTANTS OF NORTH TEXAS, of the risks, possible alternative methods for treatment, and possible consequences involved in the treatment by means of: under the general anesthesia for the relief of: Understanding this, I hereby authorize the above named doctor to administer such treatment to me. Patient or person authorized to consent for patient. Witness SURGERY AND PRE-OP/POST-OP APPOINTMENT SCHEDULE PATIENT'S NAME: ACCT# HOSPITAL: Baylor Surgicare at North Garland TIME: \_\_\_ DOCTOR'S PRE-OP DATE: DOCTOR'S PRE-OP LOCATION: HOSPITAL PRE-OP DATE: TIME: SURGERY DATE: TIME: DOCTOR'S POST-OP DATE: DOCTOR'S POST-OP LOCATION: 7150 N. Pres. George Bush Hwy #202 Garland Office \*THE HOSPITAL ADMITTING OFFICE WILL INFORM YOU OF THE EXACT TIME OF SURGERY. **AUTHORIZATION TO PAY PROVIDER** I hereby authorize payment be sent directly to the provider of medical services rendered, otherwise payment to me as determined by the insurance company. I understand I am financially responsible to the provider of services for charges not covered by this authorization. I assign benefits to ENT Consultants of North Texas and agree to act as trustee of funds in the event that they are paid to me. X Signature\_ Date AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize ENT Consultants of North Texas to release any information requested by the insurance company or its representative. Date X Signature\_

## **ENT Consultants of North Texas**

CONSENT TO TREATMENT

of treatment, and possible consequences involved in the treatment by means of:		
under the general anesthesia for the relief of:		
Understanding this, I hereby authorize the above	ve named doctor to administer such treatment to me.	
Witness	Patient or person authorized to consent for patient.	
SURGERY AND PRE-OI	P/POST-OP APPOINTMENT SCHEDULE	
PATIENT'S NAME:	ACCT#	
HOSPITAL: Presbyterian Hospital of Dalla	25	
DOCTOR'S PRE-OP DATE:	TIME:	
DOCTOR'S PRE-OP LOCATION:		
HOSPITAL PRE-OP DATE:	TIME:	
SURGERY DATE:	TIME:	
DOCTOR'S POST-OP DATE:	TIME:	
	Pres. George Bush Hwy #202 Garland Office WILL INFORM YOU OF THE EXACT TIME OF SURGERY.	
I hereby authorize payment be sent directly to the provio the insurance company. I understand I am financially re	ATION TO PAY PROVIDER  der of medical services rendered, otherwise payment to me as determined by sponsible to the provider of services for charges not covered by this worth Texas and agree to act as trustee of funds in the event that they are paid	
X Signature	Date	
AUTHORIZATION TO RELEASE INFORMATION: requested by the insurance company or its representative	I hereby authorize ENT Consultants of North Texas to release any information e.	
X Signature	Date	

## **ENT Consultants of North Texas**

CONSENT TO TREATMENT

of treatment, and possible consequences involved in the treatment by means of:		
under the general anesthesia for the relief of:		
Understanding this, I hereby authorize the abo	ve named doctor to administer such treatment to me.	
Witness	Patient or person authorized to consent for patient.	
SURGERY AND PRE-O	P/POST-OP APPOINTMENT SCHEDULE	
PATIENT'S NAME:	ACCT#	
HOSPITAL: Doctors Hospital		
DOCTOR'S PRE-OP DATE:	TIME:	
DOCTOR'S PRE-OP LOCATION:		
HOSPITAL PRE-OP DATE:	TIME:	
SURGERY DATE:	TIME:	
DOCTOR'S POST-OP DATE:	TIME:	
	. Pres. George Bush Hwy #202 Garland Office WILL INFORM YOU OF THE EXACT TIME OF SURGERY.	
I hereby authorize payment be sent directly to the provi the insurance company. I understand I am financially re	der of medical services rendered, otherwise payment to me as determined by esponsible to the provider of services for charges not covered by this North Texas and agree to act as trustee of funds in the event that they are paid	
X Signature	Date	
AUTHORIZATION TO RELEASE INFORMATION: requested by the insurance company or its representativ	I hereby authorize ENT Consultants of North Texas to release any information e.	
X Signature	Date	