

ENT Consultants of North Texas
CONSENT TO TREATMENT

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.

Witness X Patient or person authorized to consent for patient.

SURGERY AND PRE-OP/POST-OP APPOINTMENT SCHEDULE

PATIENT'S NAME: _____ ACCT# _____

HOSPITAL: *Baylor Medical Center Garland*

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: _____

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 _____

ENT CONSULTANTS OF NORTH TEXAS
7150 N. Pres. George Bush Hwy. #202
Garland, Texas 75044
(972) 414-0408

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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: (Anesthesiologist 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 INFORM YOU OF THE EXACT TIME OF SURGERY.**

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SURGERY AND PRE-OP/POST-OP APPOINTMENT SCHEDULE

PATIENT'S NAME: _____ ACCT# _____

HOSPITAL: *Baylor University Medical Center Dallas*

DOCTOR'S PRE-OP DATE: _____ TIME: _____

{GO TO WADLEY TOWER #254 FOR PRE-OP LAB & REGISTRATION}

DOCTOR'S PRE-OP LOCATION: (Nurse will call you night before surgery with time.) _____

[Call 214-820-6200 pre-admit dept. to schedule appointment date & time)

HOSPITAL PRE-OP DATE: Thursday/Friday, _____ TIME: *between 8:00am & 5:00pm*

SURGERY DATE: _____ TIME: _____

DOCTOR'S POST-OP DATE: _____ TIME: _____

DOCTOR'S POST-OP LOCATION: *3600 Gaston Avenue, Barnett Tower Dallas Office*

*NURSE WILL INFORM YOU OF THE EXACT TIME OF SURGERY.

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PATIENT'S NAME: _____ ACCT# _____

HOSPITAL: *Baylor Surgicare at North Garland*

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: _____

DOCTOR'S POST-OP LOCATION: *7150 N. Pres. George Bush Hwy #202 Garland Office*

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PATIENT'S NAME: _____ ACCT# _____

HOSPITAL: *Presbyterian Hospital of Dallas*

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: _____

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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: _____

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