ENT CARE for kids

Consent and authorization

Consent for treatment

By signing this consent, I am authorizing my physician(s) to perform and/or order another person to perform all exams, tests, procedures, and other care deemed necessary or advisable for the diagnosis and treatment of my or my child's medical condition. This consent is valid for each visit I make to ENT Care for Kids unless revoked by me in writing.

Signature of parent or legal guardian_____ Relationship _____ Date _____

Assignment of insurance benefits

I hereby authorize payment of all surgical or medical benefits directly to ENT Care for Kids. I understand that I am financially responsible to ENT Care for Kids for charges not covered by my insurance and will be billed accordingly. If applicable, I also understand that if I do not follow the requirements as outlined in my managed care benefit plan (referral forms, authorizations, etc.), I will be financially responsible for all charges and will be billed accordingly.

Authorization for release of information

I herby authorize ENT Care for Kids to furnish medical information pertinent to my medical condition including, but not limited to, the diagnosis, treatment, and care offered or rendered to me or my child. I understand this information will only be furnished: **1**) to my insurer(s) to which my or my child's medical bills have been assigned for payment; **2**) as required by law; or **3**) upon my written authorization on an acceptable form or by letter. I understand that my or my child's medical information will not be released without my express written permission. I also understand that with my written permission, my or my child's entire record can be released to the healthcare provider as specified in my written request. Any revocation of this release must be submitted in writing. For the purpose of this release, "medical information" shall mean copies of all medical records, laboratory tests (including HIV or AIDS testing), radiographic examinations, reports and/or other materials in the possession of ENT Care for Kids relating to my or my child's medical condition and proposed or actual treatment.

By signing this Consent to Release Medical Information, I agree not to hold liable ENT Care for Kids, their agents and employees, for any unfavorable outcomes as the result of releasing this information. I realize that release of my or my child's medical information may be necessary before my insurer will cover the cost of my medical treatment, and that by failing to authorize the release of this information, I may be required to pay the entire bill.

Waiver to release medical information by electronic submission

I give my permission for ENT Care for Kids to release my/my child's medical information by electronic submission (fax or internet) and release them from any and all resulting liability. I have read and understand all of the above and agree to the terms and stipulations therein.

Signature of parent or legal guardian_____ Relationship _____ Date _____

Notice concerning complaints Complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturists, may be reported for investigation at the following address:

Texas State Board of Medical Examiners
Attention: Investigations
1812 Centre Creek Drive, Suite 300
Austin, TX 78714-9134

Assistance in filing a complaint is
available by calling 1-800-201-9353.