ENT SURGICAL ASSOCIATES
THOMAS C. FRANK, M.D.
Head and Neck Surgery Pediatric and Adult Ear Nose and Throat Allergy

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GENERAL CONSENT FOR TREATMENT

***The following is a general consent for treatment for any services rendered here in the office. If your plan of treatment requires further procedures, you will be consulted on those specific procedures.*

*The consent you are about to read was written by the Texas Medical Association and requires that all physicians have patient consent for general treatment. ***

"I, knowing that I am suffering from a condition requiring diagnostic, medical or surgical treatment, do hereby voluntarily consent to such procedures and care and to such medical, surgical or other services under the general and specific instructions of the Physician of ENT Surgical Associates, their assistants, or their designee as is necessary in their judgement."

I also acknowledge that the practice of medicine is not an exact science and no guarantees have been made to me as to the result of treatments or examination by ENT Surgical Associates.

--Texas Medical Association.

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ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment of surgical/medical benefits to ENT Surgical Associates for services rendered by them in person or under their supervision. I understand that I am financially responsible for all of the fees or any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize ENT Surgical Associates to release any medical or incidental information that may be necessary for either medical care or in processing claims or applications for financial benefits.

A photocopy of these assignments shall be as valid as the original.

Print Patient Name Here: _____ Date of Birth: _____

Print Parent or Guardian Name Here: _____

Signature: _____ Date: _____