

**CONSENT FOR TREATMENT**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

*All procedures will be explained to you.  
Specialized procedures may require an additional consent form.*

I hereby consent to a general and specialized examination of my head, neck and organ systems relating to my condition. I understand that the examination and treatment may include any of the following:

- General medical history
- Inspection of my head, ears, eyes, nose, mouth, throat, and neck
- Examination with mirrors or lighted scopes (endoscopy)
- Examination of the chest, abdomen and nervous system, when appropriate
- Examination and cleaning of my ears under a microscope
- The use of topical or local anesthesia
- The use of ear impression materials for ear related products, equipment or services
- The application or injection of antibiotics or other therapeutic drugs
- The collection of secretions, sputum or drainage
- Venipuncture for blood collection
- X-rays, hearing and balance studies, or audiologic testing when indicated
- Photographic or video documentation of my findings

I have the right to ask questions regarding the purposes and risks of the examination, diagnostic studies and treatments.

I understand that this consent is effective starting today and remains in effect for all subsequent clinic visits to Children’s ENT of Houston/Mednax and applies to all physicians in the group as well as medical staff assisting the physicians.

*If the patient is a Minor (not on active military duty; not 16 years of age or older and residing outside of parent’s home; not managing own financial affairs; not unmarried parent (with custody) of child; and not confined to a Texas Criminal Justice facility) parent or legal guardian MUST SIGN BEFORE patient is examined.*

Name of consenting adult: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of consenting adult: \_\_\_\_\_ Date: \_\_\_\_\_

*When parent is a minor and is 16 years of age or older, is unmarried (with custody) of child, resides outside of parents’ home, and manages his/her own financial affairs; or is on active military duty, confined to a Texas Criminal Justice facility or otherwise legally emancipated, minor parent MUST SIGN BEFORE patient is examined.*

Name of consenting parent: \_\_\_\_\_

Signature of consenting parent: \_\_\_\_\_ Date: \_\_\_\_\_

# Welcome to Children's ENT of Houston!

In order to provide you with the best possible care please fill out both pages of this medical history form. All information is completely confidential.

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## Patient Medical History Form: Child

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

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Weight: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Pediatrician or Family Doctor: \_\_\_\_\_

Physician who referred you today: \_\_\_\_\_

Drug/Latex Allergies: \_\_\_\_\_

(if none, please write "none")

If yes, what type of reaction: \_\_\_\_\_

### History of Present Illness

What is the reason for your child's visit today? \_\_\_\_\_

How long has your child had this problem? \_\_\_\_\_

What other physician has treated your child for this problem? \_\_\_\_\_

Has your child been evaluated by any of the following?

Allergist    Pulmonologist    Speech Pathologist    Orthodontist/Dentist    Gastroenterologist

### Past Medical History

Birth history:    Full-term    Pre-term \_\_\_\_\_ # of weeks  
 Single    Twins (Fraternal \_\_\_\_ or Identical \_\_\_\_ )    Multiple # \_\_\_\_\_

Does your child no have or has he/she ever had any of the following?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> ADHD                     | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Irregular heartbeat |
| <input type="checkbox"/> AIDS/HIV positive        | <input type="checkbox"/> Down Syndrome         | <input type="checkbox"/> Kidney problems     |
| <input type="checkbox"/> Allergies                | <input type="checkbox"/> Ear infections        | <input type="checkbox"/> Lung disease        |
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Epilepsy/seizures     | <input type="checkbox"/> Psychiatric disease |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Hearing problems      | <input type="checkbox"/> Reflux disease      |
| <input type="checkbox"/> Blood disease            | <input type="checkbox"/> Heart failure         | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Blood transfusion        | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Sinus infections    |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> Strep Throat        |
| <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Hepatitis B or C      | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Cystic Fibrosis          | <input type="checkbox"/> Hospitalized at birth |  |

Please list any other serious illness not listed above: \_\_\_\_\_

### Past Hospitalization or Emergency Room Visits

Please list the date(s) and reason for any hospitalizations or emergency room visits: \_\_\_\_\_

### Past Surgical History

Please list the type(s) and date(s) of all surgical procedures your child has had: \_\_\_\_\_

**Medications**

Please list all medications your child takes regularly, including over the counter and herbal medicines:

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Any aspirin or ibuprofen use?  YES  NO How often? \_\_\_\_\_

**Review of Systems**

Does your child now have or has he/she ever had any of the following?

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Abdominal pain                  | <input type="checkbox"/> Ear fluid or infections | <input type="checkbox"/> Mouth breathing              |
| <input type="checkbox"/> Abnormal bleeding               | <input type="checkbox"/> Frequent headache       | <input type="checkbox"/> Noisy breathing              |
| <input type="checkbox"/> Anesthesia difficulties         | <input type="checkbox"/> Frequent spitting up    | <input type="checkbox"/> Sinus disease                |
| <input type="checkbox"/> Blood in stool                  | <input type="checkbox"/> Hay fever               | <input type="checkbox"/> Skin lesions/swellings       |
| <input type="checkbox"/> Breathing problems during sleep | <input type="checkbox"/> Headaches               | <input type="checkbox"/> Snoring                      |
| <input type="checkbox"/> Bruise easily                   | <input type="checkbox"/> Hearing loss            | <input type="checkbox"/> Sore throat/strep throat     |
| <input type="checkbox"/> Chest pain                      | <input type="checkbox"/> Hoarseness              | <input type="checkbox"/> Speech/Language difficulties |
| <input type="checkbox"/> Convulsions/seizures            | <input type="checkbox"/> Joint swelling          | <input type="checkbox"/> Tonsil problems              |
| <input type="checkbox"/> Cough                           | <input type="checkbox"/> Limb swelling           |   |
| <input type="checkbox"/> Dizziness                       | <input type="checkbox"/> Malignant hyperthermia  |   |

**Family Medical History**

Do any of your family members (living or dead) have any history of the following:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> AIDS                | <input type="checkbox"/> Dizziness               | <input type="checkbox"/> Kidney problems     |
| <input type="checkbox"/> Allergies           | <input type="checkbox"/> Ear fluid or infections | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Anesthesia problems | <input type="checkbox"/> Excessive bleeding      | <input type="checkbox"/> Sinus disease       |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Epilepsy/seizures       | <input type="checkbox"/> Sleep apnea         |
| <input type="checkbox"/> Blood disease       | <input type="checkbox"/> Headaches               | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Hearing loss            | <input type="checkbox"/> Thyroid disease     |
| <input type="checkbox"/> Cystic Fibrosis     | <input type="checkbox"/> Hemophilia              | <input type="checkbox"/> Tonsil problems     |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> Tuberculosis        |

Please list any other serious illness not listed above: \_\_\_\_\_

**Social History**

Is your child in daycare?  YES  NO  
Is your child in school?  YES  NO If in school, what grade? \_\_\_\_\_

Does your child use a pacifier?  YES  NO  
Does anyone in your household smoke?  YES  NO

Please list siblings and ages: \_\_\_\_\_

Please list siblings previously seen by physicians at our practice and the reason(s) for visit or treatment:

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The information provided is a complete and accurate reporting of my child's medical history and health status.

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Reviewed by physician: \_\_\_\_\_ MD Date: \_\_\_\_\_

**Patient Information**

Last name \_\_\_\_\_ First name \_\_\_\_\_

Birthdate \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If student, school attending \_\_\_\_\_

Referring physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Pediatrician/PCP \_\_\_\_\_

First Parent Last name \_\_\_\_\_ First name \_\_\_\_\_

Birthdate \_\_\_/\_\_\_/\_\_\_ Texas Drivers Lic. # \_\_\_\_\_ Occupation \_\_\_\_\_

Phone (H)(\_\_\_\_) \_\_\_\_\_ (W)(\_\_\_\_) \_\_\_\_\_ (C)(\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_ Email address \_\_\_\_\_

Second Parent Last name \_\_\_\_\_ First name \_\_\_\_\_

Birthdate \_\_\_/\_\_\_/\_\_\_ Texas Drivers Lic. # \_\_\_\_\_ Occupation \_\_\_\_\_

Phone (H)(\_\_\_\_) \_\_\_\_\_ (W)(\_\_\_\_) \_\_\_\_\_ (C)(\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_ Email address \_\_\_\_\_

Alternate Contact (when we cannot reach you) Name \_\_\_\_\_

Phone \_\_\_\_\_ Relationship to patient \_\_\_\_\_

**Insurance Information** – Please submit your insurance card and driver’s license for copying

Primary Insurance \_\_\_\_\_ Verification Phone \_\_\_\_\_

ID # \_\_\_\_\_ Group plan # \_\_\_\_\_ Employer \_\_\_\_\_

Claims Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insured’s Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Birthdate \_\_\_/\_\_\_/\_\_\_ Texas Drivers Lic. # \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Phone (H)(\_\_\_\_) \_\_\_\_\_ (W)(\_\_\_\_) \_\_\_\_\_ (C)(\_\_\_\_) \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Verification Phone \_\_\_\_\_

ID # \_\_\_\_\_ Group plan # \_\_\_\_\_ Employer \_\_\_\_\_

Claims Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insured’s Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Birthdate \_\_\_/\_\_\_/\_\_\_ Texas Drivers Lic. # \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Phone (H)(\_\_\_\_) \_\_\_\_\_ (W)(\_\_\_\_) \_\_\_\_\_ (C)(\_\_\_\_) \_\_\_\_\_

“I hereby authorize Children’s ENT of Houston/Mednax to provide any information associated with my care to my referring physician, other allied health professionals, or my insurance carrier.”

Patient/Guarantor signature \_\_\_\_\_ Date \_\_\_\_\_

**RELEASE OF MEDICAL RECORDS**

Date: \_\_\_\_\_

Re: Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender: \_\_\_\_\_

Dear Dr. \_\_\_\_\_:

This letter will authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the checkmark(s) below or otherwise release confidential information:

- \_\_\_\_\_ Complete record
- \_\_\_\_\_ Record of care from \_\_\_\_\_ to \_\_\_\_\_, only
- \_\_\_\_\_ Record of care concerning the following condition(s) \_\_\_\_\_
- \_\_\_\_\_ Other, specify: \_\_\_\_\_
- \_\_\_\_\_ Confer with another person orally about information in my medical record

**HIV/AIDS** I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical record.

Initial: \_\_\_\_\_ Date: \_\_\_\_\_

to the following person(s):

Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

The reason or purpose for this release of information is as follows: \_\_\_\_\_

I understand that you will provide this information within 15 days from receipt of request (per Medical Practice Act of the Texas State Board of Medical Examiners) and that a fee for preparing and furnishing this information may be charged. (The fee will be waived if the records are to be used for supporting an application for disability or other benefits or assistance under a) Aid to Families with Dependent Children, b) Medicaid, c) Medicare, d) Supplemental Security Income, and e) Federal Old-Age and Survivors Insurance. I have attached a statement that confirms that such an application or appeal has been filed or is pending).

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

(Patient or person legally authorized to consent on patient's behalf)

## Financial Policy

Thank you for selecting Children's ENT of Houston/Mednax (CENT) for your medical care. In order to prevent any misunderstanding over the responsibility of payment for medical and surgical services provided to our patients, we supply you with the following information:

The patient, guarantor, or the person bringing the patient (if the patient is a minor), is responsible for payment of any balance due following the office visit, test or procedure. We accept cash, personal checks (NSF charges), and credit cards (American Express, Discover, VISA, MasterCard). In the case of divorced parents, the parent bringing the child to the office is responsible for payment of any balance due at the time of service. Should you need documentation to secure reimbursement, a copy of the bill is furnished at each visit.

If a referral from your primary care physician is required by your insurance plan, it must be received in our office by your appointment time. If we have not received the referral by the time of your arrival, your appointment will be rescheduled. You will be asked for your insurance card and driver's license at the registration desk for identification purposes.

### CENT Contracted Insurance Coverage

If you have coverage through an insurance company that has a contract with the doctor you are seeing, we require a copy of your insurance card and payment of your deductible and/or co-insurance at the time of service.

### Non-CENT Contracted Insurance Coverage

If you have coverage through an insurance company that does not have a contract with the doctor you are seeing, we require a copy of your insurance card, and payment of your deductible and/or co-insurance at the time of service. We will file the claim as a service to you.

### Medicaid (applicable plans)

If you have Medicaid coverage, we must be able to verify that you have coverage on the date of the visit. If coverage cannot be verified, you must either pay for the visit or reschedule the appointment. If, within three months after the visit, you receive a retroactive card that covers the date of the visit, payment will be refunded after Medicaid has paid for the visit. You must pay for non-covered services, such as swim molds, at the time of service.

### Medicare

Office visits to a doctor are covered under Part B of the Medicare program. Medicare pays 80% of their allowable charges after you pay the \$147 annual deductible for the calendar year, and you are responsible for any non-covered services. If you have supplemental insurance, we will be glad to file it for you.

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I have read all the information above and agree that, regardless of my insurance status, I am responsible for my account balance for any professional services rendered. Disclosed, non-covered medical services are my responsibility.

In the event my insurance company is billed, I irrevocably assign and transfer benefits to Children's ENT of Houston/Mednax. A photocopy of this agreement shall be considered as effective and valid as the original.

I authorize the release of any information pertinent to my claim to any insurance company, adjuster, or attorney involved in this claim.

I authorize CENT to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature of responsible party: \_\_\_\_\_ Date: \_\_\_\_\_

*I authorize the release of any medical information necessary to process my claims.*

Signature of patient (or guardian): \_\_\_\_\_ Date: \_\_\_\_\_



Children's ENT of Houston

## Minor Child Policy

Dear Parents or Guardians:

We are prohibited by law from seeing minor children without a parent, legal guardian or designated representative present. Proof of your identity, in the form of a valid photo ID or passport, must be presented at the time of your child's visit. Please bring the appropriate identification with you when you come for your child's appointment.

If you will be sending your child to our office with a family member, friend, or care-giver, it will be necessary for you to complete the lower authorization portion of this notification, sign it and have it brought to your child's appointment by your designated representative. Your designated representative must also sign this form and, at the time of the visit, present their valid photo ID or passport.

I, \_\_\_\_\_, parent or legal guardian of \_\_\_\_\_, a minor child, grant permission to \_\_\_\_\_, my designated representative, to bring my child to Children's ENT of Houston/Mednax for care; to sign necessary paperwork to facilitate care; to provide consent; and to sign the financial responsibility documents assuring payment of any fees for which I am responsible. I warrant that any balance due will be paid by my representative at the time of service.

This authorization will remain in force until such time as I revoke it in writing.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Designated Representative

\_\_\_\_\_  
Date