ENT & Audiology Center of Southlake

Michael D. Bryan, M.D.
Diplomate of the American Board of Otolaryngology
Amy K. Mettman, M.D., P.A.
Otolaryngology-Head and Neck Surgery

Consent and Authorization

I hereby authorize my physician, _____, to release any information acquired in the course of my treatment to my insurance company, employer, or third party payer as required for claims filed, quality assurance, health plan administration, or complaints/grievances. I understand that the specific information to be released may include, but is not limited to history, diagnosis and/or treatment of all related illnesses including HIV virus and Acquired Immune Deficiency Syndrome (AIDS).

I authorize direct payment to be made to my physician for any and all medical or surgical services rendered. I understand that if any services or charges are not covered, or if the office is unable to verify eligibility, that I am responsible for all charges incurred for services rendered.

I hereby voluntarily consent to such healthcare encompassing diagnostic procedures and treatment by my physician as may be necessary in his/her judgment. Specialized procedures may require an additional consent form. I have relied on my physician for information in this regard and acknowledge that no warranty or guarantee has been made to me as a result or cure. This form has been fully explained to me, and I certify that I understand its contents.

This consent is valid for each visit I make to ENT & Audiology Center of Southlake unless revoked by me in writing.

I am over the age of 18 years and therefore have the legal right to consent to this treatment.

Patient Signature: _____ Date:_____

If patient is a Minor (under age 18, unmarried, not financially independent, not in the armed forces on active duty), parent or legal guardian MUST SIGN BEFORE patient is examined.

Patient's Name: _____ Date: _____

660 W. Southlake Blvd, # 100
Southlake, TX 76092

Telephone: 817-416-9731
Fax: 817-416-9751