

Albany ENT

Christopher J. Mann, MD -Magalie Nelson-Charles, MD -Stacey Parker, PA-C -Crystal Gay, PA-C - Julie Lambert, M.Ed, CCC-A

Date: _____

Patient's Name: _____

Patient's Date of Birth: _____

Parent/Guardian's Name: _____

In the event that a parent or legal guardian is unable to bring the above named child, I give permission for the following people to bring the child to the doctor, consent for medical care, and discuss the health issues with the staff of Albany ENT.

_____ Relationship to child _____

_____ Relationship to child _____

_____ Relationship to child _____

I give the following people permission to discuss medical bills regarding my child in the event that I am unable to be reached or bring the child myself. I understand that if I have an overdue balance or a returned check the staff may ask for payment in full, up front, before my child is seen.

_____ Relationship to child _____

_____ Relationship to child _____

Signature of Parent/Guardian: _____

This form will be kept on file. The parent/guardian may change this information by updating the form, or by submitting a request in writing.

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