



## **TO OUR PERFORMING ARTISTS: WE TRY TO EXCEED YOUR EXPECTATIONS!**

When an aspiring or professional vocalist develops a voice disorder, there can be physical, emotional, professional, social and financial consequences. Because your vocal demands are unique, we provide personalized care, state-of-the-art technology and procedures, and a concerned support staff to help you recover your best voice.

Welcome to the Texas Voice Center! Our medical and support staff are here to serve you, and want you to know what to expect when you come to our office. We offer this information in an effort to guide you through the Texas Voice Center experience, from your first appointment through your follow-up visits.

### **MAKING AN APPOINTMENT**

When you become aware of any negative change in your voice (pitch, quality, endurance, etc.), call the Texas Voice Center at (713) 796-2001 ext. 135. The Texas Voice Center secretary will talk with you about your voice symptoms, schedule an appointment, and remind you to fast three hours prior to your appointment. You can also schedule an appointment online at <http://www.texasvoicecenter.com/appointment.html>. The receptionist can also discuss the fee schedule and your insurance information to verify coverage before you come in. Please complete the following forms prior to your scheduled appointment time.

### **YOUR FIRST VISIT**

To better understand your needs, we will ask you to complete a special form for singers and actors. If you are experiencing an “acute” problem, one that has persisted for 2-5 days, we will try to schedule your visit immediately. If you are scheduled for an evaluation of a chronic problem (lasting more than 3-4 weeks) and you develop an acute illness, please call us to reschedule your appointment, as the acute illness may interfere with the proper diagnosis of the underlying chronic condition. A comprehensive evaluation of chronic problems will include:

**OBJECTIVE VOICE ANALYSIS:** We will use a computer program to analyze samples of your speaking and singing voice to obtain an accurate “picture” of your current voice. This visual profile reveals your spoken pitch range, and the status of eighteen different parameters of your voice when speaking and singing. These parameters include the status of your vocal strength, symmetry of vocal fold movements, variations in pitch and breath control, tremor, air leakage, and voice breaks.

**PULMONARY FUNCTION STUDY:** As breath support is the foundation for your voice, it is imperative to determine the status of your lung capacity that undergirds the voice.

**MEDICAL HISTORY:** A complete medical history will be taken. Please bring a *list of all* herbs, prescriptions, over-the-counter medications and other drugs you are currently taking.

**VIDEOSTROBOSCOPY:** Our state-of-the-art videostroboscopy equipment greatly enhances our ability to accurately assess how a particular pathology affects the ability of the vocal folds to vibrate in a normal way. The doctor uses a rigid scope to examine laryngeal anatomy and vocal fold movement, and a flexible scope for a similar examination during speaking and singing. For the examination, we ask that you not eat three (3) hours prior to your appointment, but you may drink water. Please take all medications as you usually do with a little food, if needed. If you are diabetic, please follow your normal eating routine.

**DIAGNOSIS AND RECOMMENDED TREATMENT:** After reviewing all the information listed above, the doctor will make a diagnosis, and recommend appropriate treatment and a follow-up visit.

**SPEECH THERAPY:** Our ASHA Certified Speech-Language Pathologist, who has expertise in treating voice disorders, will evaluate your voice during your first visit. If the doctor determines your treatment also requires voice intervention, you may be referred to our Speech-Language Pathologist for that intervention. Competent voice intervention by a qualified Speech Pathologist is often a medical necessity, and a mandatory part of voice management.



**TexasVoiceCenter**  
Voice, Swallowing, and General ENT

Dear Patient:

Thank you for choosing the Texas Voice Center for your otolaryngology specialty care. Drs. Stasney and Thekdi and the Texas Voice Center provide state-of-the-art care for all voice-related disorders, as well as swallowing and general ENT disorders.

To enable our office to provide more timely service, please complete these forms prior to your visit and present them to our front desk receptionist upon your arrival. Insurance company policies require proof of identity- *patients/guardians or your representative must present a photo ID and your insurance card/documentation at the time of your clinic visit.*

**If a referral is required by your managed care 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.**

All patients are seen in the order of scheduled appointments only. Traffic and parking can sometimes cause delays, so please allow enough travel time to assure your prompt arrival. As parking is sometimes difficult to find, using the Valet parking service can be very convenient. Valet parking rates range from \$10.00 (up to 2 hours) to \$13.00 for up to 24-hours.

In consideration of other patients, please call (713) 796- 2001 ext. 135 at least twenty-four hours prior to your scheduled appointment if you are unable to keep your appointment so that we can help you reschedule.

If you are scheduled for an evaluation of a chronic problem (lasting more than 3-4 weeks) and you develop an acute illness, please call us to reschedule your appointment, as the acute illness may interfere with the proper diagnosis of the underlying chronic condition.

We look forward to seeing you and assisting in your care.

Sincerely yours,

Dr. C. Richard Stasney, Dr. Apurva Thekdi, and Staff



**TexasVoiceCenter**  
Voice, Swallowing, and General ENT

6550 Fannin, Suite 2025  
Houston, TX 77030  
(713) 796-2001

**PATIENT INFORMATION—PLEASE PRINT**

<b>Last Name:</b>	<b>First Name:</b>	<b>Middle Initial:</b>	
<b>Circle: Mr Mrs Miss MD PhD DDS</b>	<b>Marital Status:</b>	<b>Spouse's Name:</b>	
<input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Birth Date:</b>	<b>Age:</b>	
<b>Home Address:</b>	<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Home Phone:</b>	<b>Work Phone:</b>	<b>Cell Phone:</b>	
<b>Email Address:</b>			
<b>Social Security #:</b>	<b>Driver License #:</b>	<b>State:</b>	
<b>Occupation:</b>	<b>Other Family Members Seen by TENTC:</b>		
<b>Employer &amp; Address:</b>	<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>If Student, School Attending:</b>	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time:		
<b>Full Name of Referring Physician:</b>	<b>Address:</b>	<b>City:</b>	<b>State: Zip:</b>
<b>Other Physicians Caring for You:</b>	<b>Specialty:</b>	<b>Phone:</b>	
<b>In Case of Emergency, Notify:</b>	<b>Relationship to you:</b>	<b>Home #:</b>	<b>Other #:</b>
Please list family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis:			

**FINANCIALLY RESPONSIBLE PARTY (if other than patient)**

<b>Last Name:</b>	<b>First Name:</b>	<b>Middle Initial:</b>	
<b>Home Address:</b>	<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Home Phone:</b>	<b>Work Phone:</b>	<b>Relationship to patient:</b>	
<b>Social Security #:</b>	<b>Driver License #:</b>	<b>Birth Date:</b>	<b>Age:</b>
<b>Employer &amp; Address:</b>	<b>City:</b>	<b>State:</b>	<b>Zip:</b>

**INSURANCE COVERAGE**

<b>PRIMARY Insurance Co.:</b>	<b>Member ID #:</b>		
<b>Insured's Name:</b>	<b>Relationship to Patient:</b>		
<b>Insured's ID #:</b>	<b>Insured's Soc Security #:</b>	<b>Date of Birth:</b>	
<b>SECONDARY Insurance Co.:</b>	<b>Member ID #:</b>		
<b>Insured's Name:</b>	<b>Relationship to Patient:</b>		
<b>Insured's ID #:</b>	<b>Insured's Soc Security #:</b>	<b>Date of Birth:</b>	

**AUTHORIZATION**

I hereby authorize the Texas Voice Center to furnish information associated with this illness/accident to my referring physician, other allied health professionals, or my insurance carrier.

**Patient/Guarantor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



# Texas Voice Center

Past History

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

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

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Allergies and reactions to medications: \_\_\_\_\_

Describe your present problem: \_\_\_\_\_

Please mark any medical conditions you have or have had previously.

- |  |  |
|--|--|
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Seizure               |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Head Trauma           |
| <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Kidney Trouble        |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Liver or Gall Bladder |
| <input type="checkbox"/> COPD                | <input type="checkbox"/> Cancer (type): _____  |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Glaucoma              |
| <input type="checkbox"/> Bleeding Disorder   | <input type="checkbox"/> Macular Degeneration  |
| <input type="checkbox"/> GERD                | <input type="checkbox"/> Depression            |
| <input type="checkbox"/> Thyroid Problems    | <input type="checkbox"/> Anxiety Disorder      |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Panic Attacks         |
| <input type="checkbox"/> Stroke or TIA       | <input type="checkbox"/> Other: _____          |
| <input type="checkbox"/> Neurologic Disorder |  |

List your prior Surgeries and Hospitalizations

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Marital Status:

- Single
- Married
- Divorced
- Widowed

Occupation \_\_\_\_\_

Children (ages) \_\_\_\_\_

Have you ever used tobacco? Y N

how many packs/day? \_\_\_\_\_

for how many years? \_\_\_\_\_

when did you stop? \_\_\_\_\_

How much alcohol do you use?

\_\_\_\_\_

How much caffeine do you consume daily (coffee, tea, caffeinated sodas)?

\_\_\_\_\_

### Family History

If any blood relative have had any of the following, please check and indicate which relative

- |  |  |
|--|--|
| <input type="checkbox"/> Heart Disease     | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Migraines         | <input type="checkbox"/> Cancer (type) _____ |
| <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> _____               |
| <input type="checkbox"/> Mental Illness    | <input type="checkbox"/> Other _____         |
| <input type="checkbox"/> Voice Problems    |  |
| <input type="checkbox"/> Diabetes          |  |
| <input type="checkbox"/> Thyroid Disease   |  |
| <input type="checkbox"/> Bleeding Disorder |  |
| <input type="checkbox"/> Hearing Loss      |  |

List your Medications and dosages

Aspirin or ibuprofen (Advil/Aleve)? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Previous Medications:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



# Texas Voice Center

Review of Systems

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

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

AT THIS TIME DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS OR PROBLEMS:

Yes No

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <b><u>Constitutional</u></b>               |
| <input type="checkbox"/> | <input type="checkbox"/> | fever or chills                            |
| <input type="checkbox"/> | <input type="checkbox"/> | weakness or fatigue                        |
| <input type="checkbox"/> | <input type="checkbox"/> | recent weight loss                         |
|                          |                          | <b><u>Eyes</u></b>                         |
| <input type="checkbox"/> | <input type="checkbox"/> | blurred vision                             |
| <input type="checkbox"/> | <input type="checkbox"/> | double vision                              |
|                          |                          | <b><u>Ears, Nose, Mouth and Throat</u></b> |
| <input type="checkbox"/> | <input type="checkbox"/> | trouble hearing                            |
| <input type="checkbox"/> | <input type="checkbox"/> | tinnitus or ringing in ears                |
| <input type="checkbox"/> | <input type="checkbox"/> | ear pain                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | ear infection or drainage                  |
| <input type="checkbox"/> | <input type="checkbox"/> | dizziness, vertigo or unsteadiness         |
| <input type="checkbox"/> | <input type="checkbox"/> | stuffy nose                                |
| <input type="checkbox"/> | <input type="checkbox"/> | frequent colds                             |
| <input type="checkbox"/> | <input type="checkbox"/> | sinus trouble                              |
| <input type="checkbox"/> | <input type="checkbox"/> | frequent nose bleeds                       |
| <input type="checkbox"/> | <input type="checkbox"/> | frequent sore throats                      |
| <input type="checkbox"/> | <input type="checkbox"/> | pain near teeth or mouth                   |
| <input type="checkbox"/> | <input type="checkbox"/> | hoarseness or voice change                 |
| <input type="checkbox"/> | <input type="checkbox"/> | difficulty swallowing                      |
| <input type="checkbox"/> | <input type="checkbox"/> | lumps in neck                              |
| <input type="checkbox"/> | <input type="checkbox"/> | swollen glands in neck                     |
| <input type="checkbox"/> | <input type="checkbox"/> | pain in neck                               |
|                          |                          | <b><u>Cardiovascular</u></b>               |
| <input type="checkbox"/> | <input type="checkbox"/> | heart trouble                              |
| <input type="checkbox"/> | <input type="checkbox"/> | palpitations                               |
| <input type="checkbox"/> | <input type="checkbox"/> | high blood pressure                        |
|                          |                          | <b><u>Respiratory</u></b>                  |
| <input type="checkbox"/> | <input type="checkbox"/> | cough                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | asthma or wheezing                         |
| <input type="checkbox"/> | <input type="checkbox"/> | shortness of breath                        |
|                          |                          | <b><u>Gastrointestinal</u></b>             |
| <input type="checkbox"/> | <input type="checkbox"/> | heartburn or acid reflux                   |
| <input type="checkbox"/> | <input type="checkbox"/> | nausea or vomiting                         |
| <input type="checkbox"/> | <input type="checkbox"/> | diarrhea                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | ulcers                                     |

Yes No

- |                          |                          |                                 |
|--------------------------|--------------------------|---------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <b><u>Genitourinary</u></b>     |
| <input type="checkbox"/> | <input type="checkbox"/> | kidney problems                 |
|                          |                          | <b><u>Musculoskeletal</u></b>   |
| <input type="checkbox"/> | <input type="checkbox"/> | joint pains or stiffness        |
| <input type="checkbox"/> | <input type="checkbox"/> | Integumentary                   |
| <input type="checkbox"/> | <input type="checkbox"/> | skin rashes                     |
|                          |                          | <b><u>Neurological</u></b>      |
| <input type="checkbox"/> | <input type="checkbox"/> | headaches                       |
| <input type="checkbox"/> | <input type="checkbox"/> | numbness in face, legs or arms  |
| <input type="checkbox"/> | <input type="checkbox"/> | seizures                        |
| <input type="checkbox"/> | <input type="checkbox"/> | weakness of arms or legs        |
| <input type="checkbox"/> | <input type="checkbox"/> | blackouts or fainting           |
| <input type="checkbox"/> | <input type="checkbox"/> | tremors                         |
| <input type="checkbox"/> | <input type="checkbox"/> | confusion or memory loss        |
|                          |                          | <b><u>Psychiatric</u></b>       |
| <input type="checkbox"/> | <input type="checkbox"/> | nervousness or increased stress |
| <input type="checkbox"/> | <input type="checkbox"/> | sleep problem                   |
| <input type="checkbox"/> | <input type="checkbox"/> | excessive moodiness or worry    |
|                          |                          | <b><u>Endocrine</u></b>         |
| <input type="checkbox"/> | <input type="checkbox"/> | heat or cold intolerance        |
| <input type="checkbox"/> | <input type="checkbox"/> | excessive thirst or urination   |
|                          |                          | <b><u>Hematologic</u></b>       |
| <input type="checkbox"/> | <input type="checkbox"/> | easy bruising or bleeding       |
|                          |                          | <b><u>Allergic</u></b>          |
| <input type="checkbox"/> | <input type="checkbox"/> | hay fever or dust/mold allergy  |
| <input type="checkbox"/> | <input type="checkbox"/> | food sensitivity or intolerance |
| <input type="checkbox"/> | <input type="checkbox"/> | chemical sensitivity            |

\_\_\_\_\_  
Patient Signature

# Where Do You Experience Hearing Challenges?

## Intake Questionnaire

Thank you for visiting us today. To help us provide you with the best possible care, please take a few moments to complete the following questionnaire. Your responses will help make your hearing evaluation and fitting appointment more efficient, effective and successful.

### Instructions

- Please read the following statements.
- Beside each statement, mark the circle that *best* describes your experience in each situation.

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

- |   | Always                | Sometimes             | Never                 |
|---|-----------------------|-----------------------|-----------------------|
| 1. I have to ask people to repeat themselves even when I am in a quiet conversation with one or two other people. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. My family members complain that I need to turn the television volume louder than they do.                      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. When I talk on the telephone or cell phone, I miss some of what is being said.                                 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. During a card game (or other game) around a table, I have difficulty hearing the conversation.                 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 5. When I am in a busy public place, such as a shopping center, I have difficulty communicating with others.      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 6. In meetings, I have to strain to make sure I hear everything.  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 7. When I'm eating in a restaurant, I have to ask my dining companion to repeat things.                           | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 8. I miss a lot of information during church and/or classroom lectures.   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 9. When I'm listening to music/concerts, I miss parts of the performance.   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 10. If I'm in the car with others who are talking, I can't hear what they're saying.                              | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Circle the top 3 listening situations/environments in which you experience the most difficulty hearing and would like to experience an improvement. (If not outlined above, list below).

---

---

Thank you.



Texas Center for Hearing



Texas**Voice**Center  
Voice, Swallowing, and General ENT  
**CONSENT FOR TREATMENT**

*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 understand that my medical information, including photographs or videotapes, will be handled confidentially and that my identity will remain anonymous in any presentation of case materials.”

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

“I understand that this consent remains in effect for all subsequent clinic visits to Texas Voice Center (TVC), and applies to all physicians in the group as well as medical staff assisting the physicians.”

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

Patient’s 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 \_\_\_\_\_

Signature of parent or legal guardian \_\_\_\_\_ Date \_\_\_\_\_



**FINANCIAL POLICY**

Thank you for selecting Texas Voice Center (TVC) 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 charge: \$25), 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.

TVC 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-TVC 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.

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 \$135 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.

---

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 Texas Voice Center. A photocopy of this agreement shall be considered as effective and valid as the original.

Signature of responsible party \_\_\_\_\_ Date \_\_\_\_\_  
*I authorize the release of any medical information necessary to process my claims.*

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



**TexasVoiceCenter**  
Voice, Swallowing, and General ENT

**RELEASE OF MEDICAL RECORDS**

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

To: \_\_\_\_\_  
Name  
\_\_\_\_\_  
Street  
\_\_\_\_\_  
City State ZIP

Re: Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Gender: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

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)



ACKNOWLEDGEMENT OF REVIEW OF  
TEXAS VOICE CENTER, PLLC

**NOTICE OF PRIVACY PRACTICES**

I have reviewed the Notice of Privacy Practices of Texas Voice Center, PLLC, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

---

Name of Patient

---

Name of Patient's Representative

Relationship of Patient's Representative to Patient: \_\_\_\_\_

---

Signature of Patient of Patient's Representative



**TexasVoiceCenter**  
Voice, Swallowing, and General ENT

**Smith Tower**  
**6550 Fannin Street, Suite 2025**  
**Houston, Texas 77030**  
**713-796-2001 Fax: 713-796-2349**

**Directions to our Medical Center Office:**

Smith Tower is located across from The Methodist Hospital on Fannin Street and opposite the Scurlock Tower on University Blvd. The building occupies the entire block at the intersection of Main St., University, and Fannin. Valet and self-parking areas can be accessed through any of the building's entrances. As parking is sometimes difficult to find, using the Valet parking service can be very convenient. The cost for Valet parking is the same as self-park plus any tip you may choose to give. Parking rates range from \$5.00 (up to 2 hours), to \$11.00 for 24-hour parking. Texas ENT Consultants does not validate parking tickets.

**From the West:**

Follow Interstate 10 east toward Houston; exit 610 south (past the Galleria), then merge onto 59 north (toward downtown Houston). Follow 59 north to the Greenbriar/Shepherd exit; turn right onto Greenbriar (first intersection); follow Greenbriar heading south several blocks to University Blvd. (Rice Stadium will be on the left); turn left onto University; follow University to Main Street. Smith Tower is the building across Main on the left side of the street. The parking lot is accessible from Main Street, University Blvd. and Fannin Street (although it is more difficult to enter from Fannin).

**From the East:**

Take Interstate 10 west toward Houston; exit onto 59 south toward Victoria. Follow 59 south to the Fannin Street exit, then follow Fannin south appx. 2 miles (you will pass Hermann Park and Hermann Hospital, Ross Sterling Ave. and John Freeman [Baylor Plaza] on your left). Smith Tower is on the right-hand corner of the next intersection (University Blvd). There is an entrance to Valet and self-park before the University intersection, at the NE corner of the building. There are additional entrances on University and on Main.

**From the North:**

On Interstate 45, head south to 59 south toward Victoria. Follow 59 south to the Fannin Street exit, then follow Fannin south appx. 2 miles (you will pass Hermann Park and Hermann Hospital, Ross Sterling Ave. and John Freeman Blvd [Baylor Plaza] on your left). Smith Tower is on the right-hand corner of the next intersection (University Blvd). There is an entrance to Valet and self-park before the University intersection, at the NE corner of the building. There are additional entrances on University and on Main.

**From the Northwest:**

Follow 290 southeast toward 610 south. Go past the Galleria, then merge onto 59 north (toward downtown Houston). Follow 59 north to the Greenbriar/Shepherd exit; turn right onto Greenbriar (first intersection); follow Greenbriar heading south several blocks to University Blvd. (Rice Stadium will be on the left); turn left onto University; follow University to Main Street. Smith Tower is the building across Main on the left side of the street. The parking lot is accessible from Main Street, University Blvd. and Fannin Street (although it is more difficult to enter from Fannin).

**From the Northeast:**

Follow 59 south toward Victoria; exit onto Fannin Street, then follow Fannin south appx. 2 miles (you will pass Hermann Park and Hermann Hospital, Ross Sterling Ave. and John Freeman Blvd [Baylor Plaza] on your left). Smith Tower is on the right-hand corner of the next intersection (University Blvd). There is an entrance to Valet and self-park before the University intersection, at the NE corner of the building. There are additional entrances on University and on Main.

**From the South:**

Take 288 north to 610 west. Follow 610 west to the Fannin Street exit. Turn right onto Fannin and stay to the right when the road splits. Proceed to University Blvd. (appx. the fourth intersection after the split, located directly in front of The Methodist Hospital); turn left onto University and enter the building's Valet/self-park area from the second driveway on the right.

**From the Southwest:**

Take 59 north toward Houston; exit at Greenbriar/Shepherd exit; turn right onto Greenbriar (first intersection); follow Greenbriar heading south several blocks to University Blvd. (Rice Stadium will be on the left); turn left onto University; follow University to Main Street. Smith Tower is the building across Main on the left side of the street. The parking lot is accessible from Main Street, University Blvd. and Fannin Street (although it is more difficult to enter from Fannin).

**From the Southeast:**

On Interstate 45 head north to 610 west. Follow 610 west to the Fannin Street exit. Turn right onto Fannin and stay to the right when the road splits. Proceed to University Blvd. (appx. the fourth intersection after the split, located directly in front of The Methodist Hospital); turn left onto University and enter the building's Valet/self-park area from the second driveway on the right.