

Patient's Name _____ Date of Birth _____

Privacy Notice Acknowledgement Statement

I acknowledge that I have received a copy of Northside ENT, Inc. Total Hearing Solutions
 Performance Voice Solutions Notice of Privacy Practices. Initials _____

Authorization for Messages

I authorize that lab and x-ray results may be left on my
answering machine at home..... YES NO
voice mail at work..... YES NO
cell/car phone..... YES NO

This authorization will remain in effect until I revoke it in writing. Initials _____

Consent for Out Patient Treatment

GENERAL CONSENT TO MEDICAL TREATMENT

I request and authorize the above company, its agents and employees and my physician, their associates and assistants to perform routine medical tests and procedures and to provide drugs, medical care and other services and supplies as are prescribed for my health and well-being. I acknowledge that no representatives, warranties, or guarantees as to results or cures have been made to me by the above company, nor have I relied upon any such representatives, warranties, or guarantees. I understand that attempts will be made to call me prior to my appointments. I authorize the above company to call me at the telephone numbers listed on my registration record. I acknowledge that this consent will remain in force and applies to subsequent outpatient treatment unless revoked by me in writing.

*Persons authorized under IC 16-36-1-3 to consent include a competent adult patient or an emancipated minor patient (i.e., at least 14, living apart from parents and able to support self; married, or has been married; or is in military service). If the patient is competent, consent may be provided by the patient's legal guardian or, if none, by a person appointed to do so by the patient, or if neither of the above, by the spouse, parent, adult child or adult sibling of the patient. Consent by anyone other than the patient or legal guardian cannot be contrary to the patient's previously indicated instructions concerning his health care.

NOTE: Competent means generally that one is able to understand and appreciate the benefits, risks and consequences of his/her decision. Initials _____

X _____ Date _____
(Signature of Patient, Parent/Legal Guardian if a Minor)

***This signature applies to the Privacy Notice Acknowledgement Statement, the Authorizations for Messages, and the Consent for Outpatient Treatment.**