Consent for Treatment

I voluntarily give my permission to the health care providers at Audiology and Hearing Aid Center, LLC (AHAC) as they deem necessary to provide services to me. I understand by signing this form, I am authorizing them to treat me for as long as I seek care from, or until I withdraw my consent in writing.

Your audiologist may decide it would be best to remove ear wax from your ear canal. Removing ear wax is something that is not without risk. Certain risk factors may make it more likely for you to incur complications such as bleeding or irritation. These complications may occur even if you have no risk factors but these complications are not life threatening. The process of wax removal can involve discomfort, slight bleeding, or tinnitus. If you decide you do not wish to have your wax removed at any time, you may decline or stop the procedure.

I understand that all information shared with the audiologists at AHAC, LLC is confidential and no information will be released without my consent. I further understand that there are specific and limited exceptions to this confidentiality which would include the following:

A. When there is a risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.

B. When there is suspicion that a child or an elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child or elder, and to inform the proper authorities.

C. When a valid court order is issued for medical records, AHAC, LLC is bound by law to comply with such requests.

If I have any questions regarding this consent form or about the services offered at AHAC, LLC, I may discuss them with my clinician. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by AHAC, LLC. I understand that I may stop treatment at any time.

Signature:_____

Date: _____