St. Joseph's
Ear, Nose, Throat & Allergy Clinic

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CONSENT TO TREAT I, legal adult patient or the legal guardian, consent for myself or the patient listed below to receive medical care, testing and treatment by **St Joseph's Ear, Nose, Throat & Allergy Clinic, PLLC**, and the providers. This may include medically necessary examinations, treatments, prescribing and giving medications, injections, diagnostic testing, in-office procedures, arrangement for healthcare services, emergency services by the provider, for this visit, future visits, and telehealth visits. Patient understands the providers may include physicians, nurse practitioners, physician assistants, and audiologists. Patient understands the right to consent or refuse to consent to any medically necessary treatment or procedure, except as otherwise required by law. Patient understands they have the right to discuss all medical treatments with the providers. Patient understands that the practice of medicine is not an exact science, and that diagnosis and treatment may involve the risk of injury or death. Patient understands that no guarantees have been made regarding diagnosis, treatment or care the Patient may receive. Patient understands that this consent to treatment ***must be signed***, in order, for the Patient to be seen and will be considered valid until such time that the Patient revokes this consent in writing.

CONSENT TO TELEHEALTH Patient agrees to care and treatment involving the use of electronic communications between the Patient, legal guardian, and provider transmitted by telephone and/or by video or other transmitted information to a provider who is at a different place than the Patient. Telehealth services allow healthcare providers at remote locations to share the Patient's medical information for diagnosis, therapy, follow-up, and education purposes. Patient gives consent and authorizes the Practice and the providers to forward the Patient's information to a third party as needed to receive telehealth services, and Patient understands that existing confidentiality protections apply. Patient understands that while telehealth services can be used to provide improved access to medical care, as with any medical service or procedure, there are potential risks. These risks include but are not limited to technical problems with the information transmission and equipment failures that could result in lost information or delays in treatment. Patient understands that they have a right to withhold or withdraw their consent to the use of telehealth services during treatment at any time, without affecting the Patient's right to future treatment.

RELEASE OF HEALTHCARE INFORMATION Patient authorizes the Practice to share the Patient's protected health information for treatment and payment purposes with the non-custodial adults listed below when these individuals bring the Patient to his/her visits. Patient understands they have the legal right to preauthorize treatment, and request that the Practice deliver medical treatment when the legal guardian is unable to be present for the Patient's visits and may the legal guardian telephonically. However, I understand that this authorization to treat is not contingent upon their ability to successfully reach myself as the Patient's legal guardian.

USE AND DISCLOSURE OF INFORMATION Patient consents to the use and disclosure of information from the Patient's medical records, including protected health information, by the Practice for treatment, payment, and health care operations as permitted by law. All uses and disclosures will abide by the terms identified in the Notice of Privacy Practices.

PATIENT ACKNOWLEDGEMENT I have read and understand the above consent and authorization policies.

Patient Name (Please Print): _____ Date of Birth: _____

Signature (Responsible party): _____ Date: _____

Parent/Guardian Authorization for Alternate Caregivers (if applicable)

I, _____, hereby consent to **St. Joseph's Ear, Nose, Throat & Allergy Clinic, PLLC**, allowing the below caregiver(s) to make appointments for my child and bring my child to appointments for the health care services authorized above.

_____	_____	_____
Caregiver's name	relationship to Child	Phone number
_____	_____	_____
Caregiver's name	relationship to Child	Phone number

_____	_____	_____
Parent's full legal name (please print)	Signature	Date