ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

____

Please print your name here Date of Birth

____

Signature Date

ACKNOWLEDGEMENT OF FINANCIAL POLICY

I have read, understand, and agree to the Financial Policy of Allergy, Ear, Nose & Throat Clinic.

____

Signature of Patient or Legal Guardian Relationship to Patient Date

E-PRESCRIBING CONSENT (PBM)

By signing this consent form, you are agreeing that Allergy ENT Clinic can request and use your prescription medication history from other healthcare providers/ pharmacy for treatment.

____

Signature of Patient or Legal Guardian Relationship to Patient Date

CONSENT FOR TREATMENT OF MINOR CHILDREN

ACCOMPANIED BY AN ADULT OTHER THAN PARENT OR LEGAL GUARDIAN

I,____, Authorize, Allergy ENT Clinic of NE TX to treat
(Parent or legal guardian)
____for routine and emergency medical treatment
(Child's name and DOB)
when necessary, by qualified medical personnel when accompanied by:

____

____

____

This authorization is valid for:

- Today's visit only
- From ________________(date) to______________________(date)
- Until revoked in writing by me

This consent will be valid for (1) year from the date signed unless otherwise specified in writing.

____

Printed name of parent/legal guardian

____

Signature of parent/legal guardian Date