

Eastern Carolina ENT Associates, PA
P.O. BOX 571
SMITHFIELD, NC 27577
(919)934-0948

**REQUEST FOR THE PROVISION OF MEDICAL SERVICES AND ACKNOWLEDGEMENT
OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES.**

Before you give your consent, be sure you understand the information given below. If you have any question, we will be happy to talk about them with you. You may ask for a copy of this form. I understand that I should ask questions about anything I do not understand. I understand that a provider is available to answer any questions I may have. No guarantee has been given to me as to the results that may be obtained from any services I receive. I know that it is my choice whether or not to have services. I know that at any time, I can change my mind about receiving medical services at Eastern Carolina Ear, Nose and Throat Assoc., P.A.

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law. I will be given referrals for further diagnosis or treatment if necessary. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care. I have been told how to get care in case of an emergency.

I understand that confidentiality will be maintained as much as is possible. I give permission for any and all information to be released to my insurance company if they request it for payment of services. I hereby request that a person authorized by Eastern Carolina Ear, Nose and Throat Assoc., P.A. provide appropriate evaluation, testing and treatment if I request it.

I hereby acknowledge receipt of Eastern Carolina Ear, Nose and Throat Assoc., P.A. notice of health information private practices.

Signature of Patient: _____ Date: _____

I witness the fact that the patient received the above mentioned information and said she/he read and understood the same.

Signature of Witness: _____ Date: _____

CHECK HERE IF PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW

Signature of any other person consenting _____
Relationship to patient _____ Date: _____

I witness the fact that the patient's legal guardian (or person consenting on their behalf) received the above mentioned information, and said he/she read and understood same.

Signature of Witness: _____ Date: _____