STATESBORO ENT & HEARING CLINIC
STATESBORO ENT SURGICAL CENTER, P.C.

Patient Consent for Use/Disclosure of Protected Health Information and Procedures/Treatments

IMPORTANT: **Do not sign this form without reading and understanding its contents.**

With my consent, Statesboro ENT Clinic and Statesboro ENT Surgical center may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations. Please refer to Statesboro ENT Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Statesboro ENT reserves the right to revise its notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Christa Wells, LPN, Administrator at 106 Proctor Street, Statesboro, Georgia 30458. With my consent, Statesboro ENT clinic or Surgical Center may mail and/or call to my home or other designated location and leave a message on voicemail or with a person in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminders, insurance items, patient statements, or clinical care, including laboratory results among others, as long as they are marked personal and confidential.

I have the right to request that Statesboro ENT clinic or Surgical Center restrict how it uses or discloses my protected health information to carry out treatment, payment, or healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound in this agreement. By signing this form, I am consenting to Statesboro ENT Clinic and Surgical Center's use and disclosure of my protected health information. I may revoke my consent in writing except to the extent that the practice has already made disclosures in relevance upon my prior consent. If I do not sign this consent, Statesboro ENT Clinic or Statesboro ENT Surgical Center may decline to provide treatment to me.

During the course of my care and treatment, I understand that various types of tests, diagnostic or treatment procedures may be necessary. These Procedures may be performed by physicians, nurses, technicians, physician assistants, or other healthcare professionals. While routinely performed without incident, there may be material risks associated with each Procedure. I understand that it is not possible to list every risk for every procedure and that this form only attempts to identify the most common material risks and the alternatives (if any) associated with the Procedures. I also understand that various Healthcare Professionals may have differing opinions as to what constitutes material risks and alternative Procedures.

Physical tests, assessments and treatments such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks, and other similar procedures such as needle sticks, shots, injections, intravenous injections (IV's) may have risks that include, but are not limited to, allergic reaction, nerve damage, infection, infiltration (which is fluid leaking into surrounding tissues), blood loss, disfiguring scars, loss of limb function, paralysis or partial paralysis or death. Alternatives to needle sticks include oral, rectal, nasal, or topical medications (each of which may be less effective) or the refusal of treatment, and apart from using modified procedures and/or refusal of treatment, no practical alternatives exist for physical tests and assessments.

Administration of Medications whether orally, rectally, topically or through my eye, ear, or nose may have risks associated including, but are not limited to, perforation, puncture, infection, allergic reaction, brain damage or death. Apart from varying the method of administration and/or refusal of treatment, no practical alternatives exist. Drawing Blood, Bodily Fluids or Tissue Samples such as that done for laboratory testing and analysis also may have material risks associated including, but are not limited to, paralysis or partial paralysis, nerve damage, infection, bleeding and loss of limb function. Apart from long-term observation and/or refusal of treatment, no practical alternatives exist. The insertion of internal tubes such as bladder catheterizations, nasogastric tubes, and rectal tubes, also may have material risks including, but are not limited to, internal injuries, bleeding,

infection, allergic reaction, loss of bladder control and/or difficulty urinating after catheter removal. Apart from external collective devices and/or refusal of treatment, no practical alternatives exist.

If I have any questions or concerns regarding these Procedures, I will ask my physician to provide me with additional information. I also understand that my physician may ask me to sign additional Informed Consent documents.

I understand that:

The practice of medicine is not exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME concerning the outcome and/or result of any Procedure.

The Healthcare Professionals participating in my care will rely on my documented medical history, as well as other information obtained from me, my family, or others having knowledge about me, in determining whether to perform or recommend the Procedures; therefore, I agree to provide accurate and complete information about my medical history and conditions; and Physicians rendering services to me are independent professionals engaged in the private practice of Medicine (and are not employees or agents of the Hospital).

By signing this form:

I consent to Healthcare Professionals performing Procedures as they deem reasonably necessary or desirable in the exercise of their professional judgment, including those Procedures that may be unforeseen or not known to be needed at the time this consent is obtained; and I acknowledge that I have been informed in general terms of nature and purpose of the Procedures, the material risks of the Procedures, and the practical alternatives to the Procedures.

Signature of Patient/Legal Guardian: _____

Printed Name of Patient/Legal Guardian:_____

Patient's Name (if Minor) _____

Date Signed:_____

Explained/Witnessed By:_____