



Patient Acknowledgement of Policies

Please initial on the line by each statement.

1. I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Queen City Ear Nose and Throat and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Queen City Ear Nose and Throat. _____

2. I agree to be contacted via email or SMS with information related to my visit, like: a patient portal invitation, post-visit satisfaction survey, appointment or checkup reminders, health tips, or new services that relate to me or my family. _____

3. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the Queen City Ear Nose and Throat Notice of Privacy Practices. I acknowledge that I have the right to a printed copy of our privacy policy and that it is available on the company website. _____

4. I authorize payment of medical benefits to Queen City Ear Nose and Throat physicians or their designee for services rendered. _____

5. I give permission to obtain all my medication/prescription history when using an electronic system to process. _____

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