

**THE ENT CENTER OF NEW BRAUNFELS**  
**The Office of Dr. Marc Franklin**

PATIENT ACKNOWLEDGMENT

By signing this document below and by initialing each paragraph, the patient or responsible party acknowledges they have read and understand the following:

INSURANCE LIMITATIONS

\_\_\_\_\_ Most insurance carries require a written referral form from a Primary Care Physician in advance of service provided. Patients or person responsible for the patient must (1) obtain physician referrals and (2) contact the insurance carrier to verify benefits in advance of service. At the time of service, patients are responsible for payment for non-covered services, deductibles and co-insurance.

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY POLICY

\_\_\_\_\_ By signing this registration form, I acknowledge receipt of The ENT Center of New Braunfels, Privacy Policy Notice. I understand my rights to privacy and know if I have any questions or specific requests that I may direct them to the Office Manager.

**I consent The ENT Center of New Braunfels, to discuss my protected health information with the following family member's, significant others or friends:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone # (    ) \_\_\_\_\_ Work/Cell# (    ) \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone # (    ) \_\_\_\_\_ Work/Cell # (    ) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

CONSENT TO TREAT

\_\_\_\_\_ I hereby volunteer consent to my treatment at the ENT Center of New Braunfels, and authorize such treatments, examinations and diagnostic procedures.

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Signature of Patient or Responsible Party \_\_\_\_\_

Witnessed By \_\_\_\_\_ Date \_\_\_\_\_